Melbourne Health
Annual Report 2016/17

MELBOURNE HEALTH

The Royal Melbourne Hospital

NorthWestern Mental Health

Doherty

OUR VISION

Our vision is to be *First in Care, Research and Learning* to improve outcomes for our community and Victorians.

Care

First in delivering safe and high quality care

Research

First in evidence-based research integrated into practice

Learning

First in developing our workforce and community

OUR VALUES

Our values and behaviours guide the way we work together to achieve our vision.

Caring

We treat everyone with kindness and compassion

Excellence

We are committed to learning and innovation

Integrity

We are open, honest and fair

Respect

We treat everyone with respect and dignity at all times

Unity

We work together for the benefit of all

OUR PRIORITIES

We aim to achieve our vision by focusing on six strategic priorities.

Care and outcomes

We deliver outstanding care and outcomes

Patient and consumer experience

We partner with and empower our patients and consumers

Innovation and transformation

We embrace innovative thinking in everything we do

Workforce and culture

We enable our people to be the best they can be

Collaboration

We maximise the potential of our partnerships

Sustainability

We are recognised, respected and sustainable health services

Front cover:
Our cover image focuses on women in surgery. It was inspired by Malika Favre's 'Operating Theatre' which featured on the cover of The New Yorker magazine in April 2017.

Clockwise from top: Dr Cassandra Hidajat, Resident; Dr Liz Pemberton, Anaesthetist; Associate Professor Kate Drummond, Neurosurgeon; Abigail Ryburn, Scrub Nurse.

Back cover:
Top: Alice Bennett, Program Manager, Cyril Jewell House and Safety Champion.

Bottom: Professor Peter Colman AM, Director, Diabetes and Endocrinology – awarded a Member of the Order of Australia in the 2017 Queen's Birthday Honours.

Photography: MH Medical Illustration

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Chairman & Chief Executive's Report

We are pleased to present the 2016/17 Annual Report for Melbourne Health.

The Rt Hon Robert Doyle AC Chairman

Professor Christine Kilpatrick Chief Executive

This year has been exceptional in many ways.

As one of the most highly regarded public health services in Australia, we deliver outstanding care and treatment for individual patients, we improve outcomes for all through a comprehensive, internationally recognised medical research program and we provide world-class training for our current and future health professionals.

Last year we provided more than 98,900 inpatient separations across our acute, sub-acute, mental health and residential care facilities, an increase of more than 6300 on last year.

Our Emergency Department at The Royal Melbourne Hospital (RMH) provided more than 74,000 people with urgent medical treatment, compared with over 68,500 the year before. More than 184,100 outpatient appointments were held, an increase of more than 6000 compared with the previous year.

There were more than 5000 acute admissions across our NorthWestern Mental Health (NWMH) adult, youth and aged services and our staff provided more than 331,000 service 'contacts' in the community.

At the Peter Doherty Institute for Infection and Immunity, $30 million in grant funding was secured as it became the hosting partner for three new Centres for Research Excellence.

But it's not only the numbers that tell the story.

Each year, our staff dedicate themselves to saving thousands of lives, and improving health and wellbeing outcomes for individuals and communities. We thank them for their dedication and commitment to providing safe and high quality care that is underpinned by evidence-based research and excellence in learning.

We also extend a heartfelt thanks to each and every one of the over 400 volunteers who selflessly gave their time throughout the year. From helping our patients and visitors find their way around the hospital to serving cups of tea, their generosity, friendship and kindness touched the lives of many.

> "Melbourne Health continues to grow and evolve into a health service of which all Victorians can feel proud"
>
> THE RT HON ROBERT DOYLE AC, CHAIRMAN

> "I have been immensely impressed by the professionalism of the Melbourne Health team and look forward to continuing our very important contribution to the Victorian community"
>
> PROFESSOR CHRISTINE KILPATRICK, CHIEF EXECUTIVE

Strategic Plan – Progress and results

Our vision to be *First in Care, Research and Learning,* sets the standard that we strive for, the tone of our organisational priorities and influences our values and our culture. In 2016/17, we completed the second year of our five year Strategic Plan. A review of our progress against our strategic priorities demonstrates tremendous achievements including:

- *Care and Outcomes:* even though our Emergency Department presentations grew by 8 per cent, we continued to improve our emergency four-hour length of stay and ambulance offloading performance. In addition, our elective surgery waiting list dropped significantly (from 3077 in 2015/16 to 2621 in 2016/17) due to hard work across the organisation.
- *Patient Experience:* we achieved our best ever *Victorian Healthcare Experience Survey* (VHES) result with 95.9 per cent of RMH adult inpatients rating their experience as very good or good in Quarter 3, compared with the state average of 94.6 per cent.
- *Innovation and Transformation:* the opening of the RMH Clinical Trials Centre will deliver great patient care while supporting groundbreaking research.
- *Workforce and Culture:* our *Speaking up for Safety* program, a training program helping staff respectfully raise concerns to enhance teamwork and prevent avoidable harm, continues to gain strength.
- *Collaboration:* the Collaborative Framework, with local community partners, has continued its work on improvements to the primary care and acute health interface. This has included an annual forum and projects in end of life care, diabetes and chronic heart failure.
- *Sustainability:* in the Victorian Premier's Sustainability Awards 2016, we won the Health category for the program *Reducing Waste, One Dialysis Patient at a Time*, with a range of waste reduction initiatives.

Building and strengthening our workforce culture

Our Cultural Transformation Program was developed in response to concerns raised by staff and a growing awareness of the significant negative impact that culture-related issues were having on our staff, patients and consumers.

The program was launched in early 2016, commencing a long term commitment to making Melbourne Health a great place to work and a great place to receive care.

Recognising there are many variables in culture, the program includes activity across change management, anti-bullying, communication and engagement, leadership, safety culture and values.

These elements establish and monitor behavioural expectations, build high performing teams, develop strong leaders and managers, and create a culture where feedback is openly and professionally given and received.

A central feature of the program has been the introduction of the Safety Culture Program – including leadership development, training in *Speaking up for Safety* and a professional accountability framework, weCare, to enable feedback about unprofessional behaviour.

Realising that up to 95 per cent of Victorian healthcare workers have personally experienced verbal or physical assault, we are providing active support for the Occupational Violence and Aggression in Healthcare public awareness campaign launched by the Victorian Government.

The campaign aims to improve awareness of the effect occupational violence and aggression has on healthcare workers – with the message that violence and aggression against healthcare workers is never okay. While supporting this campaign, we are also intensifying our focus on preventing and managing occupational violence and aggression through a number of initiatives across Melbourne Health.

Delivering safe and high quality care

We are very proud of the significant improvements we continue to make in providing safe and high quality care for our patients and consumers.

During the year we began implementing the Adult Sepsis Pathway, aimed at empowering clinical staff to identify the risk factors, symptoms and signs of sepsis (the body's systemic response to infection) and respond quickly with initial management actions and escalation. Since its implementation, there has been a reduction in mortality, length of stay and Intensive Care admissions.

Our contagion rates for Staphylococcus aureus bloodstream (SAB) infection have significantly dropped over the last seven years as we continue working towards our target of zero. Overall, our healthcare associated SAB rate has been below the Department of Health and Human Services (DHHS) target rate for over two years and our results compare favourably with other tertiary Victorian hospitals.

Since the inception of the central line associated bloodstream infection (CLABSI) prevention collaborative in 2011, our infection rates remain low as we head towards a target of zero. Of note, there were zero CLABSI incidents in quarter 4 of 2015/16 which continued into quarter 1 of 2016/17 – a great result with overall performance significantly improving in the 2016/17 year.

And our hand hygiene compliance rate has been above 80 per cent, the state target, since October 2016, a tremendous achievement.

Major works across Melbourne Health

In July 2016, the Victorian Comprehensive Cancer Centre (VCCC) was officially opened by the Victorian Premier, the Hon. Daniel Andrews, heralding a new future for cancer treatment, research and collaborations in the state.

The $10.9 billion Metro Tunnel includes five new underground stations including a new station at Parkville, under Grattan Street near Royal Parade. Important enabling works for this critical infrastructure project commenced during the year and Melbourne Health continues to work with the Metro Rail Authority to ensure we keep staff, patients and visitors informed, while minimising and managing disruption and access issues.

Melbourne Health was successful in securing funds of $40 million in the 2017/18 State Budget for critical infrastructure improvements at RMH City and Royal Park campuses. These works will be a focus over the coming year and will help us continue to improve patient safety and care.

Our new NWMH Broadmeadows Inpatient Unit Intensive Care Unit was officially opened by Mr Frank McGuire, Local Member for Broadmeadows in December 2016. The $1.7 million upgrade included the complete retrofit of the current intensive care beds to ensure we continue to provide best practice care.

Early work has commenced on a detailed master planning process for RMH, in close consultation with the DHHS. A full business case for Government consideration is currently being developed.

Melbourne Health, Peter MacCallum Cancer Centre and The Royal Women's Hospital will continue to work together with Government to secure a Parkville Electronic Medical Record (EMR) that will allow our precinct to transform the way we provide safe and high quality care.

The patient experience

As a responsible community leader, we are committed to improving the patient experience, especially those people who are disadvantaged or vulnerable.

Responding to patient requests to improve the level of information we provide on discharge, Patient Discharge Information Letters are now given to all multi-day patients discharged home from RMH wards. The multidisciplinary team completes the form throughout the patient stay and reviews with the patient and family on the day of discharge. This is a great example of how a small change in practice can benefit the patient experience.

Recognising that LGBTI Victorians experience poorer health outcomes than the general population, Melbourne Health is embarking on a journey to develop effective inclusive practices for our LGBTI patients, consumers and staff.

Melbourne Health's telehealth service received additional funding to expand. We already deliver an effective telehealth service to regional and rural Victoria as part of our Refugee Health program and will now be able to extend medical services to a wider range of patients.

Since its establishment a year ago, the Information Sharing Project between NWMH and the Critical Incident Response Team (CIRT) at Victoria Police has been a pivotal step in assisting police negotiators deal with people suffering from mental illnesses. NWMH acts as a state-wide 'portal' for requests from CIRT and in the past 12 months, the program has helped to reduce time on scene and the use of force and weaponry.

During the year, the Victorian Infectious Diseases Reference Laboratory (VIDRL), based at the Doherty Institute, identified a new strain of norovirus and predicted it would become the next gastro pandemic in Victoria. Norovirus is the most common cause of viral gastroenteritis, and our scientists predict it has the potential to become a worldwide epidemic.

A new Viral Hepatitis Clinic was set up within VIDRL to further improve access for the over 100,000 Victorians living with viral hepatitis.

Other highlights from the year include:

- We held the official launch of the Aboriginal and Torres Strait Islander (ATSI) flags and our e-Learning package, designed to build awareness of cultural considerations for ATSI patient who attend RMH
- We officially launched a new legal service for inpatients and outpatients of the RMH. Working with Inner Melbourne Community Legal, the 'Health-Justice Partnership' provides legal assistance for patients as one of the components of holistic care
- In June 2017, we announced that RMH was one of four health services to receive funding in the inaugural round of the DHHS Language Services Innovation Grants program to help healthcare workers deliver interpreting services that better meet the needs of non-English speaking patients

Awards, recognition and accolades

At Melbourne Health, our staff and our programs are acknowledged as Australian and world leaders.

Our staff continue to be the bedrock of our success. Their commitment to ensuring our patients and the broader Victorian community have access to high quality healthcare is unwavering. Across a range of diverse fields, during the year, many of them were recognised for their professional contribution – these include:

- At the Victorian Public Healthcare Awards, a NWMH program that supports consumers to get back on track through the Assisted Intensive Medication Service won the category of Improving Equity. And, a Merri Health and RMH collaboration won the Excellence in Providing Alternative Care Paths for the *Back pain Assessment and Management Service in Primary Care* program.
- Our internationally renowned stroke expert Professor Stephen Davis AM was honoured with the 2017 visiting C Miller Fisher Professorship at the Massachusetts General Hospital, Harvard University
- Associate Professor Steven Tong, Infectious Diseases Physician at RMH and Indigenous Health Theme Leader at the Doherty Institute, was awarded the 2017 Frank Fenner Award for Advanced Research in Infectious Diseases
- Professor Jeff Szer was elected President-Elect of the World Marrow Donor Association
- Our Procurement team won a prestigious award from the Chartered Institute of Procurement and Supply for the Best Contribution to the Reputation of Procurement and was runner up in the Most Improved Procurement Operation – Start Up category
- Dr Jai Darvall, Anaesthetist and ICU Consultant, was awarded the highly esteemed Gilbert Brown Research Prize by the Australian and New Zealand College of Anaesthetists
- Our Finance team won two of the four national awards at the Health Finance Management Association awards
- The British Association of Urological Surgeons awarded Professor Tony Costello AM the prestigious 2017 St Peter's Medal, the first Australian recipient, for his pioneering contribution in prostate anatomy, robotics and laser treatment
- Professor Dennis Velakoulis, Clinical Director, Melbourne Neuropsychiatry Centre NWMH and University of Melbourne, received the Professional Excellence Award at the annual Hellenic Australian Chamber of Commerce and Industry Excellence Awards
- Jennifer Burger, Carer Consultant from NWMH, won an award at the 2016 Mental Health Services conference for her 40 year service to mental health
- Professor Terry O'Brien, Professor Ian Wicks and Professor Trevor Kilpatrick were elected as new Fellows of the Australian Academy of Health and Medical Sciences

98,900+

INPATIENT SEPARATIONS ACROSS OUR ACUTE, SUB-ACUTE, MENTAL HEALTH AND RESIDENTIAL CARE FACILITIES, AN INCREASE OF MORE THAN 6300 ON LAST YEAR

74,000+

PEOPLE WERE PROVIDED WITH URGENT MEDICAL TREATMENT, COMPARED WITH OVER 68,500 THE YEAR BEFORE

The following people were recognised in the 2017 Australia Day Honours.

Dr John Graeme Sloman AO was awarded an Officer of the Order of Australia for distinguished service to medicine, particularly to the specialty of cardiology, as a clinician, through advisory roles with a range of medical organisations, and to the community.

Dr Emma O'Brien OAM was awarded a Medal of the Order of Australia for her service to community health through music therapy programs.

The following people were recognised in the 2017 Queen's Birthday Honours.

The Rt Hon Robert Doyle AC who has been Chair of Melbourne Health since 2007, was awarded the Companion of the Order of Australia for his roles in local government, to the Parliament of Victoria, particularly in the areas of health and public administration, and to the community as a supporter of youth, social welfare and medical research foundations.

Professor James St. John AO has been awarded an Officer of the Order of Australia for his distinguished service to medicine, and to medical research, as a gastroenterologist, to innovative public health cancer screening programs, and as a mentor of young clinicians.

Professor Peter Colman AM, Director of the Department of Diabetes and Endocrinology was awarded a Member of the Order of Australia for his significant service to medicine in the field of endocrinology, particularly diabetes research, patient education and clinical management.

184,100+

OUTPATIENT APPOINTMENTS WERE HELD, AN INCREASE OF MORE THAN 6000 COMPARED WITH THE PREVIOUS YEAR

5000+

ACUTE ADMISSIONS ACROSS OUR NWMH ADULT, YOUTH AND AGED SERVICES

Living research and leading technological innovation

2016/17 was an exceptional year for our research and technological innovation.

Clinicians from all fields – medicine, nursing and allied health – are increasingly involved in research to improve the care of our patients and this is reflected in the breadth of our publications. In 2016, staff at Melbourne Health published 1220 publications as well as book reviews, chapters and article reprints.

During the year, the University of Melbourne in partnership with RMH, was the only Australian group to join Epilepsy Centre Without Walls, a $28 million project focusing on people with epilepsy acquired following brain trauma. The global push, funded by the US National Institutes of Health for research, aims to find a long-awaited research breakthrough to develop treatments that, for the first time, could prevent or mitigate this disabling and potentially life-threatening condition.

RMH was the only Australian hospital to take part in an international randomised control trial known as DAWN. The trial results extend the window of endovascular clot retrieval treatment time for eligible patients from zero to six hours, to six to 24 hours after stroke onset, dramatically reducing the chances of permanent disability, and allowing more patients to return home sooner.

In May 2017, funding of $450,000 from the Victorian Government was announced for the Melbourne Health Accelerator, a program that brings together clinicians and researchers to develop new technologies to manage some of the most pressing challenges facing our healthcare system today.

In another first, a new cannabis gel currently being trialed at RMH could be the answer for some patients with adult epileptic seizures. Applied to the skin on the upper arms, it is hoped that the cannabidiol gel will reduce the number and severity of seizures for adults with partial-onset seizures.

The findings of an international study led by Australian researchers, including researchers from RMH, that will influence how doctors treat Multiple Sclerosis, were published in The Lancet in February 2017. The study compares the effectiveness of current treatments, giving real-time reassurance to patients that they are receiving the right treatment.

In a bid to cure Parkinson's disease, medical researchers at RMH have trialed a new revolutionary type of stem cell that is injected into the brain as part of a world-first clinical trial. The phase one study, which involves 12 patients with moderate to severe Parkinson's, uses neural stem cells derived from unfertilised eggs. Following transplantation, patients will be monitored for 12 months at specified intervals, to evaluate the safety and the effects of the neural stem cells.

This year, we saw links with our Parkville partners strengthen with progress surrounding the Melbourne Genomics Health Alliance. The Alliance aims to integrate genomic information into everyday healthcare and personalised medicine. A ground-breaking genomic sequencing project led by the Alliance received $25 million in Victorian Government funding, which will see around 2000 Victorians access genomic sequencing tests over four years.

During the year, the Australian Rehabilitation Research Centre (ARRC) was launched. A virtual centre dedicated to the advancement of rehabilitation research and practice at RMH, the ARRC features innovation in caring for disabled people within the public hospital system.

In February, Melbourne Health entered into a strategic partnership alliance with QuintilesIMS (the world's biggest contract research organisation) as the newest member of their global PRIME Site Network, a small group of carefully selected sites from around the world who are elite performers in the clinical research arena. RMH is the only PRIME Site in Australia.

As well as leading and participating in research, adopting and adapting 'firsts' in medical technology is central to what we do.

During the year, we took on new state-of-the-art technology, the Brainlab Automatic Registration System, which provides real-time imagery to neurosurgeons mid-operation so they can precisely pinpoint and navigate brain tumours during surgery.

In another Australian milestone for patients with Parkinson's disease, RMH has used Deep Brain Stimulation and Bluetooth technology to treat and manage symptoms. Deep Brain Stimulation delivers mild electrical pulses to specific targets in the brain to stimulate the structures involved in motor control. The new technology allows doctors to deliver stimulation more precisely to targeted areas of the brain. The patient also receives a controller so they may adjust the level of stimulation.

In an Australian-first trial, a dedicated stroke ambulance, with a mobile CT brain scanner, will hit the road in late 2017 as part of a pilot study to provide the quickest possible diagnosis and treatment for patients suffering a life threatening stroke. In 2016/17, this trial was boosted with a further $7.5 million over four years from the Victorian Government.

Board and Executive acknowledgements

Professor Christine Kilpatrick began as Chief Executive in May 2017. Christine brings tremendous experience to Melbourne Health having held the position of Chief Executive Officer of The Royal Children's Hospital since July 2008. Prior to her appointment at The Royal Children's Hospital, Christine held positions here at Melbourne Health, including Executive Director Medical Services and Executive Director of the RMH.

On behalf of the Melbourne Health Board and Executive, we would like to most sincerely thank the following people for their contribution during 2016/17.

Dr Gareth Goodier finished as Chief Executive in October 2016 to take up his new appointment as Executive Chair of the Melbourne Biomedical Precinct.

Adam Horsburgh was appointed Interim Chief Executive between October 2016 and May 2017, and was then appointed as Deputy Chief Executive/Chief Operating Officer from May 2017.

On our Board, we sincerely thank the contributions of Bill Mountford, Des Pearson and David Cartwright who finished at the end of the 2015/16 year. In addition, we thank Dr Victoria Atkinson and Michael Gorton AM who completed their directorships throughout the 2016/17 year.

In 2016/17 we welcomed new Directors; Eugene Arocca, Jennifer Kanis, Gregory Tweedly and Professor Shitij Kapur.

You can see from this report, it has been another busy, productive, outstanding year for Melbourne Health. Our Board, staff and volunteers dedicate themselves every day to the operation of this great health service, driven to help the lives of thousands of Victorians with professionalism, compassion and world-class healthcare.

As we move towards the 170th anniversary of the RMH in 2018, we look forward to celebrating this very significant milestone with all Victorians who have shared, and continue to share our journey.

The Rt Hon Robert Doyle AC
Chairman

Professor Christine Kilpatrick
Chief Executive

In accordance with the *Financial Management Act 1994*, I am pleased to present the Report of Operations for Melbourne Health for the year ending 30 June, 2017.

The Rt Hon Robert Doyle AC
Chairman

Melbourne
14 August 2017

Report of Operations

Board of Directors

Melbourne Health was established in July 2000 under the Health Services Act 1988 (Victoria).

The Board comprises nine independent non-executive directors.

The Board is accountable to the Minister for Health. Its role is to exercise governance in the achievement of Melbourne Health's objectives as detailed in the Melbourne Health Strategic Plan 2015–2020 and Melbourne Health Annual Business Plan. This necessarily includes all of the following:

- Setting the strategic direction and priorities for Melbourne Health and monitoring compliance
- Approving financial and business, risk and audit plans, and budgets to ensure the accountable and efficient provision of health services by Melbourne Health and its long-term financial viability
- The establishment and maintenance of effective systems to ensure the health services provided meet the needs of the communities served by Melbourne Health
- Monitoring the performance of the Chief Executive each financial year, against agreed strategic plans
- Through the Chief Executive, monitoring the effectiveness of arrangements with other relevant agencies and service providers to enable effective and efficient health service delivery and continuity of care
- Advising the Minister for Health and the Secretary of the Department on significant Board decisions and issues of public concern, which may affect Melbourne Health
- Facilitating health research and education
- Adopting a code of conduct for staff of Melbourne Health
- Providing appropriate training for Board directors and embedding regular Board performance evaluation

In December 2010, the Board endorsed the Melbourne Health Corporate Governance Framework, which provides an outline of the key elements of corporate governance structures at Melbourne Health.

The Directors for 2016/17 were:

The Rt Hon Mr Robert Doyle AC – Chairman
Appointed to the Melbourne Health Board in July 2007.

Robert Doyle AC was elected in 2008, 2012 and 2016 and is the serving Lord Mayor of Melbourne. Robert is a Principal at The Nous Group, a management consultancy business based in Melbourne and, since 2007, has been Chairman of Melbourne Health (The Royal Melbourne Hospital).

Robert is President of the Lord Mayor's Charitable Foundation, Chairman of the Royal Melbourne Hospital Foundation and a Trustee of the Shrine of Remembrance. Robert is also an Ambassador for Odyssey House, a drug and alcohol abuse rehabilitation facility, an Ambassador for SecondBite, a not-for profit organisation committed to making a positive difference by distributing fresh food to the disadvantaged and homeless, an ex-officio member of Cancer Council Victoria and an Ambassador for Field of Women, a charity raising awareness of breast cancer, an Ambassador for the White Ribbon Day Foundation, an international day for the elimination of violence against women, an Ambassador for the Juvenile Diabetes Research Foundation, the Honorary President of the Melbourne Region of the Scout Association and a Board member of the Plumbing Industry Climate Action Centre (PICAC) Ltd. Robert is an advisory board member of the World Economic Forum (DAVOS).

In 2010 Robert was made a Fellow of Monash University. Robert recently joined the United Nations Advisory Committee of Local Authorities (UNACLA) as a committee member. A Member of Victoria's Parliament for 14 years, Robert was Leader of the Opposition and Leader of the Liberal Party for four years. He has also been Shadow Minister for Health and, in government, Parliamentary Secretary for Health. In 2016 Robert was admitted as Doctors to Law (Honoris causa) at Monash University.

Dr Victoria Atkinson
Appointed to the Melbourne Health Board in July 2016 and resigned in May 2017.

Dr Victoria Atkinson is the Chief Medical Officer and Group General Manager Clinical Governance for St Vincent's Health Australia. She is also an experienced cardiothoracic surgeon.

Victoria joined the Melbourne Health Board in June 2016 after a long clinical and administrative career at The Royal Melbourne Hospital. Victoria left RMH in June 2015 and joined St Vincent's Health Australia as the Chief Medical Officer and Group General Manager of Clinical Governance with responsibility for developing a unified and integrated approach to clinical care and innovation across the organisation.

She has interests in transformational change projects, professional accountability, clinical and operational innovation as well as hospital design and believes strongly in the ongoing evolution of healthcare delivery.

Victoria holds an MBBS, FRACS, and a Masters of Health Management. She is a Graduate of the Australian Institute of Company Directors and holds an EDAC qualification from the Center for Healthcare Design in the USA.

Mr Eugene Arocca
Appointed to the Melbourne Health Board in July 2016.

Eugene Arocca graduated from Monash University in 1983 with degrees in Jurisprudence and Law.

In the same year, he started employment with Maurice Blackburn and was appointed partner at the firm in 1990. In 1996 he was appointed lawyer for the Collingwood Football Club where he also acted as a board member from 2002 to 2005.

In late 2005, he retired from both Maurice Blackburn as a senior partner and as a Collingwood board member to become Chief Operating Officer and Corporate Counsel for Collingwood. During that time, he oversaw the club's growing interests in external and non-football commercial operations.

In January, 2008 he left Collingwood to accept the position of CEO of the North Melbourne Football Club. He drove a number of historic and important initiatives during his time as CEO, including the development of 'The Huddle' – an innovative community and education facility operated by the football club, which won a Premier's Award for Excellence in 2012 and the Australian Migration Council's Award for Sports Leadership in 2013.

Mr Arocca resigned from North Melbourne in mid-2012 and started as CEO of Confederation of Australian Motor Sport (CAMS) in October 2012. Under his leadership CAMS has experienced year on year record growth in participation and revenue.

Eugene is an ambassador for the White Ribbon Foundation, an ambassador for the Jodi Lee Foundation, and was an Australia Day Ambassador in 2011. He is a member of the Law Institute of Victoria and the Australian Institute of Company Directors.

Since 2014, Eugene has been a non-executive director of Western Leisure Services Pty Ltd, a subsidiary of Wyndham City Council, responsible for the management of three key leisure facilities within the municipality, including indoor and outdoor aquatic centres and an indoor sports stadium.

Mrs Jane Bell
Appointed to the Melbourne Health Board in July 2009.

Jane Bell is a banking and finance lawyer with more than 20 years' experience in leading law firms, financial services and corporate treasury operations gained living in Melbourne, London, Toronto, San Francisco and Brisbane.

Jane currently serves on the Board of UCA Funds Management Limited and its subsidiaries, Deputy Chair of Biomedical Research Victoria, Chair of the Advisory Committee of the Melbourne Genomics Health Alliance, and member of the Audit Committee of The Salvation Army. Jane is a former Board member of WorkSafe Victoria, Australian Red Cross (Queensland), Monash Institute of Medical Research, Prince Henry's Institute of Medical Research, Queensland Institute of Medical Research, Victorian Women's Housing Association and Deputy Chair of Westernport Water Corporation.

Jane holds a Bachelor of Laws from the University of Melbourne, Bachelor of Economics from Monash University and a Master of Laws from Kings College, London and is a Fellow of the Australian Institute of Company Directors.

Mr Michael Gorton AM
Appointed to the Melbourne Health Board in July 2008.

Michael Gorton AM is a Partner in a Melbourne law firm, Russell Kennedy Solicitors. He is also Chair of the Agency Management Committee of AHPRA and a Board member of the Australasian College for Emergency Medicine and Melbourne Primary Care Network. He has had government roles, including Chair, VEOHRC; President of the Health Services Review Council; Chair of the Biotechnology Ethics Advisory Committee and Chair of the Infertility Treatment Authority. He has also been a member of the Advisory Board of the Monash Institute for Medical Research; National President of Greening Australia and inaugural Co-Chair of Reconciliation Victoria Inc. Michael advises many of the Australasian medical colleges, and for his work was awarded Honorary Fellowships with Royal Australasian College of Surgeons and Australian & New Zealand College of Anaesthetists and was made a Member in the Order of Australia in 2004 for his community contribution.

Ms Penelope Hutchinson
Appointed to the Melbourne Health Board in November 2015.

Penny Hutchinson's career began in chartered accountancy, in England, before she migrated to Australia in 1983. Penny was a Deputy Secretary in the Department of Premier and Cabinet from 2000–15, primarily as Director Arts Victoria, also acting in other Deputy Secretary roles and serving on secondment to the Department of Environment, Land, Water and Planning.

At BDO, Penny led the consulting division which focused on a core client base across many portfolios in the Victorian Public Sector – including health, transport, treasury, environment and community services. Before that, she was a senior policy officer at the Department of Management and Budget and the National Companies and Securities Commission.

From 1985 to 1993, Penny tutored in accounting at Ormond College, University of Melbourne and from 1980 to 1993 she also held the position of Director of Studies for Commerce. Penny has served on various boards, including Medibank Private, Swanston Trams, Federal Airports Corporation, Victorian Rehabilitation Services Pty Ltd, the Victorian Council of Social Service, the Victorian College of the Arts and Monash University. From 2005–11 Penny was a member of the Regional Council of the Institute of Chartered Accountants and was Chair in 2009.

Penny has a degree in German and Music from the University of London. She has a diploma of music performance in the clarinet, a Masters in Public Policy at the University of Melbourne, is a fellow of the Institute of Chartered Accountants in Australia and a graduate of the Institute of Company Directors.

Ms Angela Jackson
Appointed to the Melbourne Health Board in September 2015.

Angela Jackson is an experienced public sector economist with 15 years of experience, including as an economic adviser in the Department of Prime Minister and Cabinet and Deputy Chief of Staff to Australia's Finance Minister. In 2011, Angela completed her Masters in International Health Policy (Health Economics) with Distinction from the London School of Economics and Political Science.

Angela is currently undertaking a PhD in health economics at the Monash University Centre for Health Economics, alongside looking after her two young children.

Ms Jennifer Kanis
Appointed to the Melbourne Health Board in July 2016.

Jennifer Kanis has qualifications in law, education and arts. She heads the Social Justice Practice at Maurice Blackburn Lawyers. Previously Jennifer was the Director of Advocacy and Campaigns at the Asylum Seeker Resource Centre.

Jennifer was a City of Melbourne Councillor from 2008 to 2012 where she held the portfolio areas of community services and arts and culture. From 2012 to 2014, Jennifer was the State Member for Melbourne, she held the positions of Shadow Parliamentary Secretary for Justice and Mental Health and was Deputy Chair of the Victorian Parliament's Accountability and Oversight Committee and Independent Broad-based Anti-Corruption Committee.

Jennifer's legal practice was in the areas of employment, industrial relations and anti-discrimination law. She was also a secondary school teacher and senior school coordinator. Jennifer is also currently a director at Victorian Legal Aid.

She has previously been a director of Housing Choices Australia and the Melbourne Symphony Orchestra.

Professor Shitij Kapur
Appointed to the Melbourne Health Board in December 2016.

Professor Shitij Kapur, FRCPC, PhD, FMedSci is the Dean, Faculty of Medicine, Dentistry and Health Sciences and Assistant Vice-Chancellor (Health), University of Melbourne. Shitij is a clinician-scientist with expertise in psychiatry, neuroscience and brain imaging. He trained as a Psychiatrist at the University of Pittsburgh, and undertook a PhD and Fellowship at the University of Toronto. He is a Diplomate of the American Board of Psychiatry and Neurology, similarly Board Certified in Canada and has a specialist medical license in the United Kingdom.

Professor Kapur's main research interest is in understanding Schizophrenia and its treatment. He has used brain imaging, animals models and clinical studies which have led to a better understanding of antipsychotic action, its relationship to brain dopamine receptor blockade, the role of appropriate dosing of these drugs and has led to the development of the 'salience' framework of psychosis and the 'early onset' hypothesis if antipsychotic action. He is now working on how 'biomarkers' might be best incorporated into psychiatric care and drug development. Shitij has published 300 peer-reviewed papers, his work has received over 25,000 citations as he has made numerous presentations worldwide. He serves in advisory capacity to public charities and pharmaceutical companies and has received national and international awards including the AE Bennett Award of the Society for Biological Psychiatry, Paul Janssen Award of the CINP. He is a Distinguished Fellow of the American Psychiatric Association and the Fellow of the Academy of Medical

Sciences, UK, and Fellow of King's College London, UK. He led NEWMEDS, an EU-wide Innovative Medicines Initiative and STRATA, a UK-wide program to enhance stratified medicine strategies in psychiatry.

Professor Kapur's former position was Executive Dean Institute of Psychiatry, Psychology and Neuroscience (IoPPN), Europe's largest and leading centre for mental health research. Prior to this role, Shitij was Vice-President (Research) for the Centre for Addiction and Mental Health (CAMH) Toronto. CAMH is both a large hospital and university affiliated research institute and is Canada's premier centre for research into mental health and addictions.

Shitij has served as a Non-Executive Director of the South London and Maudsley NHS Trust in the US, as Secretary [Honorary] of the International College of the Neuropsychopharmacology (CINP) and a Treasurer of the Schizophrenia International Research Society (SIRS). He currently serves on the Board of the Royal Melbourne Hospital, the Walter and Eliza Hall Institute and the St. Vincent's Research Institute in Melbourne.

Mr Greg Tweedly
Appointed to the Melbourne Health Board in July 2016.

Greg Tweedly is an experienced Victorian public sector manager with nearly 40 years' experience in a variety of Victorian public sector organisations.

Greg was a former director and Chief Executive of Worksafe Victoria 2003 to 2012. He has held senior management and financial positions in the Transport Accident Commission (TAC), the Victorian Workcover Authority, Public Transport Authority, State Transit Authority (V/Line) and the Melbourne Metropolitan Board of Works.

He is currently a non-executive director of Dorsavi Ltd. and Chair of the Personal Injury Foundation. He was previously a director and chairman of the Victorian Trauma Foundation, director of the Personal Injury Education Foundation, director of the Emergency Services Telecommunications Authority, chair of the Heads of Workers Compensation Authorities for Australian and New Zealand and the member representing Victoria on SafeWork Australia and its predecessor bodies.

In 2015, he was independent chair of a ministerial inquiry into the use of chemical substances by employees of the former Victorian Department of Crown Lands and Survey. Greg has a commerce degree from University of Melbourne, is a CPA and is a graduate of the Australian Institute of Directors.

More information about Melbourne Health's Strategic Plan, Board responsibilities and Director's experience can be found at **www.thermh.org.au**

Board Committees

The Board has established a number of sub-committees and advisory committees, which are also attended by members of the Melbourne Health Executive. The Chairman is an ex officio of each committee.

Community Advisory Committee
Board membership: Mrs Jane Bell (Chair) and members of the community in which Melbourne Health operates.

Primary Care and Population Health Advisory Committee
Board membership: Ms Jennifer Kanis (Chair), Ms Penny Hutchinson

Audit Committee
Board membership: Ms Penny Hutchinson (Chair), Mrs Jane Bell, Mr Greg Tweedly

Finance Committee
Board membership: Ms Angela Jackson (Chair), Mr Michael Gorton AM, Mr Eugene Arocca

Foundation Committee
Board membership: The Rt Hon Robert Doyle AC (Chair)

Clinical Governance and Improvement Committee (Quality Committee)
Board membership: Mr Michael Gorton AM (Chair), Dr Victoria Atkinson, Mr Greg Tweedly, Ms Angela Jackson

Remuneration Committee
Board membership: The Rt Hon Robert Doyle AC (Chair), Mrs Jane Bell, Ms Penny Hutchinson

Melbourne Health at a Glance

We are a leading public health service in Victoria with a history of providing the best possible care for our patients and consumers. We are committed to applying evidence based research to drive improvements in clinical outcomes and healthcare experience. With a focus on teaching and education, we encourage lifelong learning to enable our people to realise their potential.

Serving a population base of over 1 million, our world-class reputation had its beginnings in the RMH – Victoria's first public hospital – established in 1848 to answer the need for public health services for a rapidly growing town. For almost 170 years, we have provided a comprehensive range of acute, sub-acute and community public health services to our local community within Melbourne's west and north, and as well as regional and rural Victorians and interstate patients and consumers.

Today we provide care through three key services:

The Royal Melbourne Hospital

Our acute and sub-acute academic health service

As one of the largest hospitals in Victoria, the RMH in Parkville provides a comprehensive range of health services across two campuses.

Our City campus provides general and specialist medical and surgical acute services. Sub-acute services, including rehabilitation and aged care, outpatient and community programs are provided from our Royal Park campus.

The RMH plays a key role within the broader Victorian health sector as a major Victorian referral service for specialist and complex care, and is a designated state-wide provider for services including adult trauma. It also contains centres of excellence for tertiary services in several key specialties including neurosciences, nephrology, oncology, cardiology and genomics.

NorthWestern Mental Health

Our mental health service

As the largest provider of mental health services in Victoria, NWMH works in partnership with consumers and carers to provide a comprehensive suite of general and specialist services to youth, adult and aged people within the community, residential and health services.

Services are delivered through six programs spanning 24 sites across the northern and western suburbs of Melbourne reaching communities based in Broadmeadows to the north, Preston to the east and Sunshine to the west.

It also delivers a number of state-wide services including the neuropsychiatry service and the eating disorders service.

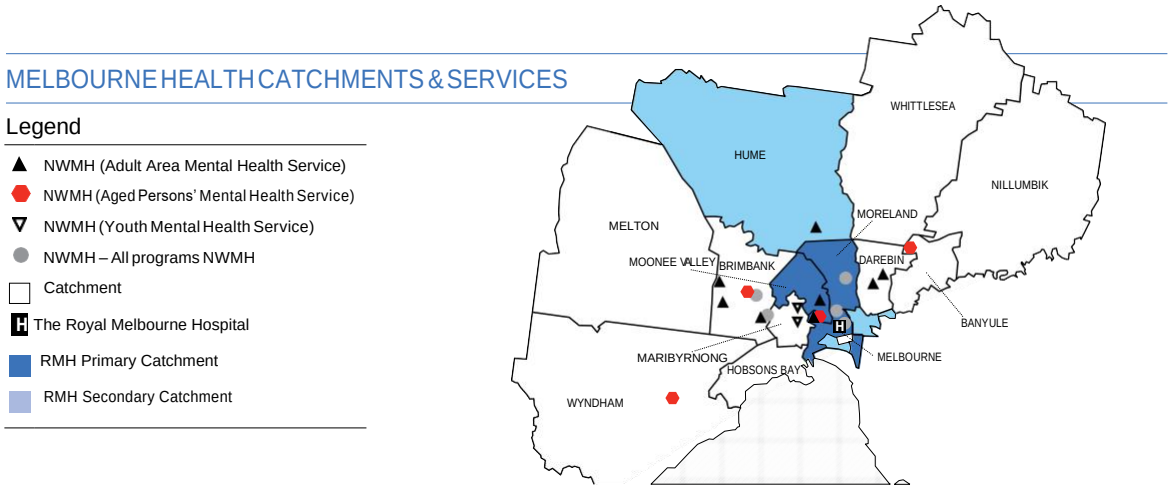
The Peter Doherty Institute for Infection and Immunity

Our infection and immunity service

The Doherty Institute, our partnership with the University of Melbourne, aims to be a world-class institute that combines research into infectious disease and immunity with teaching excellence, reference laboratory diagnostic services, epidemiology and clinical services. Our services at the Doherty Institute include:

- The Victorian Infectious Diseases Reference Laboratory
- VICNISS Healthcare Associated Infection Surveillance System
- The Victorian Infectious Diseases Service
- The Victorian Tuberculosis Program
- National Centre for Antimicrobial Stewardship
- World Health Organisation Collaborating Centre for Reference and Research on Influenza
- World Health Organisation Collaborating Centre for Viral Hepatitis

MELBOURNE HEALTH CATCHMENTS & SERVICES



Melbourne Health Organisation Structure as at 30 June 2017

Melbourne Health Board

Chief Executive, Professor Christine Kilpatrick~

- **Director, Strategy & Planning,** Stephen Ratcliffe**
- **Director, Transformation & Quality Planning,** Fiona Watson
- **Director, Public Affairs,** Nicky Webster

Deputy Chief Executive/Chief Operating Officer Mr Adam Horsburgh~	• Access • Cardiovascular, Renal & Endocrine Services • Critical Care & Investigative Services	• Enterprise Risk Management • Information & Performance • Medicine & Community Care • Neurosciences, Cancer & Infection Medicine	• Outpatients • Project Management Office • Surgery, Perioperative, Trauma & Surgical Oncology
Executive Director Corporate & Information Services Mrs Sally Campbell	• Capital Works • Commercial Operations* • Facilities Management	• Health Sciences Library • Information Technology • Information Project Management	• Infrastructure Services • Legal Counsel • Retail
Executive Director People & Culture Ms Bridgid Connors	• Cultural Transformation Program • Employee Relations • Employee Services & Remuneration	• Occupational Health & Wellbeing • Organisational Development	• People Management & Operation • Workforce Planning & Recruitment
Executive Director Nursing Services & Allied Health A/Prof Denise Heinjus	• Allied Health • Clinical Policies & Procedures • Emergency Management Planning	• Nurse Bank • Nurse Education • Nursing Workforce Unit	• Associate Professor Emergency Nursing • Professional Nursing Practice
Executive Director Finance & Logistics Mr George Kapitelli	• Financial Performance & Analysis • Financial Business Management • Financial Reporting & Auditing	• Finance Services* • Financial Systems* • Procurement	• Contract Management • Supply & Logistics • The Royal Melbourne Hospital Foundation
Executive Director Clinical Governance & Medical Services Dr Cate Kelly	• Collaborative Framework • Infection Prevention & Surveillance Service • Medical Education	• Medical Governance • Medical Workforce Unit • Medicolegal • Staff Clinic	• Transformation & Quality • VICNISS • VIDRL
Executive Director NorthWestern Mental Health A/Prof Ruth Vine	• Aged Persons' Mental Health Program • Inner West AMHS^	• Mid West AMHS • Northern AMHS	• North West AMHS • Orygen Youth Health
Executive Director Research Prof Ingrid Winship	• Business Development^^ • Clinical Trials • Human Research Ethics Committee	• Melbourne EpiCentre • Research Advisory Council • Research Funding • Research Governance	• Research Grants • Research Staff

*Shared resource ^Area Mental Health Service ~ From May 2017 **From September 2016 ^^From July 2016

Our Clinical Services

Allied Health

Aboriginal Health Services
Audiology
Clinical Nutrition
Facial Prosthetics
Music Therapy
Occupational Therapy
Pastoral Care
Physiotherapy & Exercise Physiology
Podiatry
Prosthetics & Orthotics
Psychology
Social Work
Speech Pathology
Transcultural & Interpreting Services

Cardiovascular, Renal & Endocrine Services

Bone Mineral Service
Cardiac Surgery
Cardiology
Diabetes
Diabetes Foot Service
Dialysis
Endocrinology
Metabolic Service
Nephrology
Renal Surgery
Renal Transplant
Thoracic Surgery
Vascular Surgery

Critical Care & Investigative Services

BreastScreen
Emergency
Imaging
Intensive Care Unit
Medical Illustration
Pathology
Pharmacy
Organ Donation

Medicine & Community Care

Acute Medical Unit
Addiction Medicine
Aged Care Assessment Service
Case Management
Community Partnerships Unit
Community Therapy Services
Department of Aged Care
Gardenview House
General Medicine
Geriatric Evaluation and Management Inpatient Units
Hospital Admission Risk Program
Hospital In The Home
In Reach
Respiratory Medicine & Sleep Disorders
Sub Acute Ambulatory Care Service
Transition Care Program

Neurosciences, Cancer & Infection Medicine

Bone Marrow Transplant
Dermatology
Familial Cancer Centre/Genetic Medicine
Haematology
Immunology
Neurology
Neurosurgery
Ophthalmology
Palliative Care
Rehabilitation
Rheumatology
Victorian Infectious Diseases Service

NorthWestern Mental Health

Assessment & Treatment Planning – Aged
Centre of Excellence in Eating Disorders
Continuing Care Teams – Youth
Eating Disorders – Inpatients, Outpatients, Statewide Training and Education
Inpatient Treatment – Youth, Adult and Aged
Integrated Community Teams – Adult
Mental Health Triage Service
Neuropsychiatry – Inpatients & Outpatients
Prevention and Recovery Care (PARC) Services – Adult
Rehabilitation, Community Care Units, Secure Extended Care – Adult
Residential Care – Adult & Aged
Substance Use & Mental Health Treatment
Youth Access Teams – Youth

Surgery, Perioperative, Trauma & Surgical Oncology

Anaesthetics
Breast Service
Colorectal Medicine
Ear, Nose & Throat and Head & Neck Oncology
Gastroenterology
Oral & Maxillofacial
Orthopaedics
Pain Management
Perioperative Services
Plastics and Reconstructive Surgery
Special Surgery
Trauma
Urology

University of Melbourne Chairs

Cato Professor of Psychiatry
Professor Ian Everall

Chair of Neuroscience
Professor Trevor Kilpatrick

Chair of Old Age Psychiatry
Professor Nicola Lautenschlager

Edgar Rouse Professor of Radiology
Professor Patricia Desmond

James Stewart Professor of Medicine
Professor Terence O'Brien

James Stewart Professor of Surgery
Professor Andrew Kaye

NHMRC Professorial Fellow (Cardiology)
Professor Jon Kalman

NHMRC Professorial Fellow (Neurology)
Professor Helmut Butzkueven

Professor of Adult Clinical Genetics
Professor Ingrid Winship

Professor of General Medicine & Aged Care
Professor Andrea Maier

Professor of Aged Neurology
Professor Cassandra Szoeke

Professor of Clinical Epidemiology
Professor Sanjoy Paul

Professor of Gastrointestinal Oncology
Professor Alex Boussioutas

Professor of Medical Education
Professor Geoff McColl

Professor of Medicine (Endocrinology)
Professor John Wark

Professor of Medicine (Infectious Diseases)
Professor Bev Biggs

Professor of Neurology
Professor Patrick Kwan

Professor of Neuropsychiatry
Professor Christos Pantelis

Professor of Psychiatry
Professor Dennis Velakoulis

Professor of Radiology
Professor Peter Mitchell

Professor of Surgery (Cardiothoracics)
Professor Alistair Royce

Professor of Translational Neuroscience
Professor Stephen Davis

Australian Catholic University Chair

Professor of Mental Health Nursing
Professor Kim Foster

La Trobe University Chairs

Professors of Allied Health

Professor Karen Willis
Professor Catherine Itsiopoulos
Associate Professor Karl Landorf
Associate Professor Anthony McGillion (Clinical Nursing Practice)
Dr Mary Whiteside

Significant Supporters

The Royal Melbourne Hospital Foundation acknowledges the following significant support:

Major Contributions

Guthrie Family Charitable Trust
Global Genealogy Pty Ltd
The Justin Foundation
J & M Nolan Family Trust

Mr Michael & Mrs Eleanor Allan
Ms Betty Amsden, AO
Mr Nick Belegrinos
Mr Rodney Blakeney
Mr Joey & Mrs Julie Borensztajn
Mr Stefan & Mrs Nevenka Bradica
Mr Andrew Brookes & Mrs Robina Brookes
Ms Miriam Brown
Mr Merak Chan
Dr Marion Cincotta
Mrs Sue Clifton
Mr Peter Copulos
Mrs June Danks
Mr Nigel Dymond
Mr Alan & Dr Elizabeth Finkel
Dr Kum Fok
Mr Lindsay Fox AC
Dr John & Mrs Diana Frew
Mrs Liz Haskew
Mrs Barbara Haynes, OAM
Mrs Miriam Henry
Mr Mark & Mrs Sara Kagan
Mr Robert Kirby
Mr Alan & Mrs Debbie Kras
Ms Agnes Lam
Prof Finlay Macrae, AO
Mrs Jocelyn Mead
Mr Andrew Michelmore & Mrs Janet Michelmore AO
Mrs Pamela Miller
Mr Adrian Mordech
Mr Lindsay Mott
Mr Baillieu Myer, AC & Mrs Sarah Myer
Mrs Beverley Noonan
Mr Donald Packenham
Ms Nancy Price
Mr Ian & Mrs Rosli Reid
Mr Phillip Schmidt
Mr Gregory V Shalit & Mrs Miriam Faine
Mr Clive Smith
Mrs Chi Tang
Mr Carlo Ursida
Mr Nick Vujanic
Mr Lloyd Williams
Mr Richard Wynne

Corporate Partners

Major Contributions
Merz Australia Pty Ltd
OPTUS Business
PACCAR Australia

Academy Services
Allergan
BankVic
Bayer Australia Ltd Pharmaceuticals
Bendigo Property Services
CBD Development Group
Ckaos Ink Pty Ltd
Coles–Barkly Square & Union Square
Commonwealth Bank – Royal Melbourne Hospital Branch
Daniels Health
De Bortoli Wines
DPM Financial Services
EFM Health Clubs
FCG Property
First State Super
Glenvill
HealthSmart Pharmacy – Royal Melbourne Hospital
IPSEN Pty Ltd
Johnson & Johnson Pty Ltd
Medikane Pty Ltd
Melbourne Recital Centre
Mundipharma Pty Ltd
Perplexing New Reality
QuintilesIMS
S.O. Asher Consultants Pty Ltd
Seqirus (Australia) Pty Ltd
Smartsalary
Summit Fleet Leasing & Management
Swingshift Nurses

Trusts & Foundations

Brian Smith Memorial Award (Equity Trustees)
Collier Charitable Fund
Edwards Foundation
Esso Australia (Exxon Mobil)
Felice Rosemary Lloyd Scholarship (Equity Trustees)
Fight Cancer Foundation
Hugh T. Williamson Foundation (Equity Trustees)
JB Were Trust
Karin Joy Bulmer (Equity Trustees)
Lord Mayor's Charitable Foundation
NAB Staff Fund
Perpetual Trustees
Price Family Foundation
State Trustees Australia Foundation
The Bell Charitable Fund
Walter & Eliza Hall Trust
William Buckland Foundation

Community Supporters

Dry July Foundation
Lions Breakfast Club Geelong Inc
Longwarry Primary School
Matty's Soldiers
Melbourne Neuropsychiatry Centre
Merv Irvine Nursing Home
Nordia Foundation Pty Ltd
Pallaconian Brotherhood Elderly Committee
Urban Earthworks
Yarra Valley Hockey Club

Ms Silvana Bianchi
Ms Fiona Brockhoff
Mrs Melissa Chen
Mrs Judy Manning
Ms Semeel Nersou
Mr John Pstepancic
Ms Sara Taji
Ms Alicia Van Hemert

Estates & Gifts in Will

Estate of John Anderson
Louis Berner Charitable Trust
Estate of John Edward Bowlen
Mary Evelyn Bowley Charitable Trust
Estate of Henrietta Lucy Cherry
Estate of Irene Daisy Dike
Estate of Ethel Mary Drummond
Estate of George Lawrence Godfree
Estate of Louisa Henty
Estate of Joseph Herman
Estate of Patricia Catherine Jackman
Estate of Margaret Jill Jacobs
Doris & Rupert Joseph Charitable Trust
Estate of Richard Kearton
Joseph Kronheimer Charitable Fund
Estate of John Lambrick
Estate of Joseph & Kate Levi
Mary MacGregor Trust
Estate of William Macrow
Estate of William Marshall
Estate of Mary Mason
Estate of J R G & E McKenzie
Estate of Margaret Lillian Merrifield
Eugene & Janet O'Sullivan Trust
Thomas B Payne Fund
Mr & Mrs Simon Rothberg Charitable Trust
Estate of Steven Robert Smith
Albert Spatt Charitable Trust
John Henry James Symon Charitable Trust
Mary Symon Charitable Trust
Estate of Pamela Turner
Louis John Wahlers Trust Fund
Eliza Wallis Charitable Trust
Ernest & Letitia Wears' Memorial Trust
Werge Batters Perpetual Charitable Fund
Charles Wright Trust
Estate of John Frederick Wright

Occupational Health, Safety & Wellbeing

During 2016/17 Melbourne Health continued to build on the progress of projects from previous years as well developing and implementing new initiatives which continue our focus on developing a progressive and proactive safety culture.

The non-clinical Manual Handling Project was completed and has been extremely successful in reducing injuries and claims. An increase in awareness of manual handling risks and the introduction of a wide range of new controls to prevent or reduce the risks associated with hazardous manual handling helped achieve this.

We significantly revised our workplace bullying policy framework, which included creating new policies and procedures to improve how we report and investigate bullying and harassment issues. Melbourne Health will continue to implement the recommendations from the Victorian Auditor-General's Office report, the DHHS Framework (*Our pathway to change*) and Royal Australasian College of Surgeons review.

Melbourne Health has continued its strong focus on health and wellbeing by rolling out the Combatting Compassion Fatigue Program across our Intensive Care Unit and Emergency Department. The program provides psychological first aid and self-help skills to staff that are regularly exposed to emotionally traumatic events in the workplace. Shorter versions of the program have also been developed to meet the needs of specific work areas.

A Mental Health Strategic Framework has been developed to raise awareness of mental health issues and proactively identify and mitigate psychological risk factors that may occur in the workplace.

The prevention and management of occupational violence and aggression remains a major focus for Melbourne Health and as such, a new strategy has been developed to combat this significant risk area. Implementation of the strategic interventions has begun and will continue to be rolled out in 2017/18.

Occupational Violence

Occupational violence statistics	2016/17
WorkCover accepted claims with an occupational violence cause per 100 FTE	0.17
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	1.04
Number of occupational violence incidents reported	1717*
Number of occupational violence incidents reported per 100 FTE	26.4
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	15.6

*The actual number of occupational violence incident appears higher than previous years due to improved data capture and incident reporting.

Definitions

For the purposes of the above statistics the following definitions apply.

Occupational violence – any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.

Incident – occupational health and safety incidents reported in the health service reporting system. Code Grey reporting is not included.

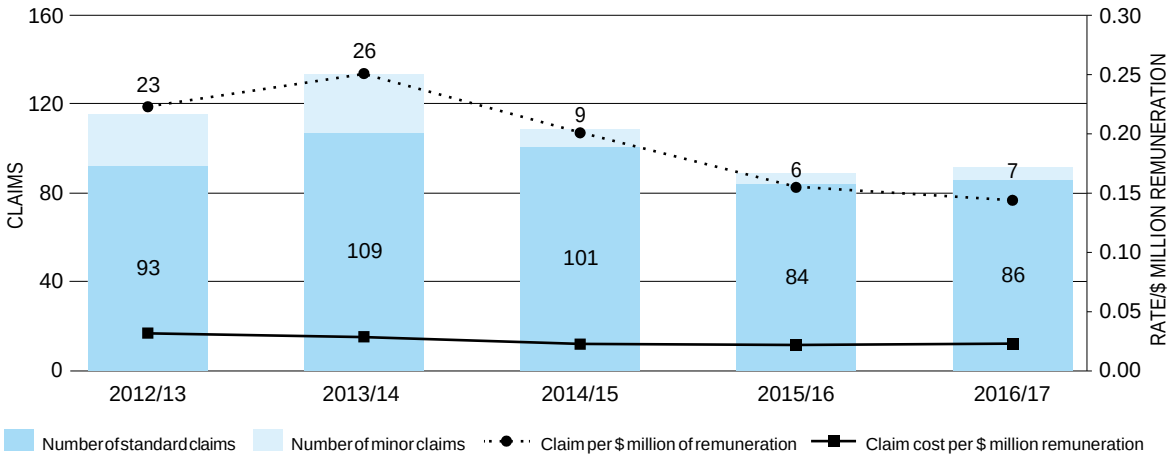
Accepted Workcover claims – accepted WorkCover claims there were lodged in 2016/17.

Lost time – is defined as greater than one day or shift.

Injury, illness or condition – this includes all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.

WORKCOVER PERFORMANCE 2012/13 TO 2016/17

Melbourne Health's WorkCover claims performance remains steady



MELBOURNE HEALTH EMPLOYEES 2016/17

Hospitals Labour Category	June Current Month FTE		June YTD FTE	
	2016	2017	2016	2017
Administration/Clerical	1205.45	1236.76	1190.67	1210.77
Allied Health	604.74	623.24	604.74	613.10
HMO's	521.30	565.29	476.38	544.46
Hotel/Allied	422.20	428.44	393.78	426.60
Medical	130.68	137.30	131.73	137.15
Medical Support	776.40	842.27	756.02	815.44
Nursing	2616.56	2740.17	2579.07	2665.15
Sessional Clinical	264.53	261.13	264.53	256.23
Total	6541.87	6834.60	6396.91	6668.90

General Information

Carers Recognition Act 2012

Melbourne Health is committed to partnering with and empowering our patients and consumers. We understand that our patients and consumers, their families and carers need to play an active role in their own healthcare and in helping us improve the quality and safety of our services.

We take all practicable measures to ensure our employees and agents reflect the care relationship principles in developing, providing or evaluating support and assistance for persons in care relationships.

The Melbourne Health Respect and Partnerships in Care Strategy provides an organisation-wide framework describing our approach to embedding person-centred care and partnerships in our culture, decision making and treatment.

Recognising that everyone in the organisation has an impact on patient and consumer experience, a Partnering with Consumers education package, incorporating principles of cultural responsiveness and person-centred care, is mandatory for all Melbourne Health staff – both clinical and non-clinical. This learning tool draws particular attention to the needs of carers and families.

Melbourne Health reports on how we engage with our patients, consumers, their families and carers in the annual Quality of Care Report. That report is available on our website at **www.thermh.org.au** and also is distributed in hardcopy throughout Melbourne Health and our service catchment area.

Requests for print versions can be made to:
Transformation and Quality,
The Royal Melbourne Hospital.

Freedom of Information

The *Freedom of Information Act 1982* provides a legally enforceable right of public access to information held by government agencies. All applications made to Melbourne Health under the *Freedom of Information Act 1982*, were processed in accordance with that Act. Melbourne Health provides a report on these requests to the Freedom of Information Commissioner. Applications and requests for information about making applications, under the Act can be made to:

Postal Applications
Freedom of Information Officer
Health Information Services
Post Office
ROYAL MELBOURNE HOSPITAL
VICTORIA 3050

Hand delivery
Freedom of Information Officer
Health Information Services
The Royal Melbourne Hospital
– City Campus
300 Grattan Street
PARKVILLE VICTORIA 3050

Telephone: (03) 9342 7781
Facsimile: (03) 9342 8008
Email: FOIrequest@mh.org.au

More information about Melbourne Health can be found on our website at **www.thermh.org.au**, including how we manage FOI requests, publications, and other material that can be inspected by the public.

Freedom of Information applications	Melbourne Health
Received during the year	2924
In progress at the start of the year	188
Granted in full	2277
Denied in part	121
Denied in full	4
Withdrawn	191
In Progress	181
Transferred to another service	6
Transferred from another service	4
No Record	9

Privacy

Melbourne Health is committed to protecting the privacy of its patients and clients. The organisation is required by law to protect personal and confidential information such as information about an individual's health and other personal details. Melbourne Health complies with all applicable legislation relating to confidentiality and privacy, including, where relevant, the *Health Services Act*, *Mental Health Act* and the *Health Records Act*. Melbourne Health's Privacy Policy is available to all staff on the Melbourne Health intranet site and available to the public in hardcopy. Melbourne Health adheres to the Department of Health's privacy policy which can be accessed online at **www.thermh.org.au**

Preventing detrimental action

Melbourne Health is committed to extend the protections under the *Protected Disclosure Act 2012* (Vic) to individuals who make protected disclosures under that Act or who cooperate with investigations into protected disclosures. The procedure and brochure are available to all staff on the Melbourne Health intranet site and to the public at **www.thermh.org.au**

Merit and Equity Principles

Merit and equity principles are encompassed in all employment and diversity management activities throughout Melbourne Health.

Melbourne Health is an equal opportunity employer and is committed to providing for its employees a work environment which is free of harassment or discrimination together with an environment that is safe and without risk to health.

Melbourne Health's employees are committed to our values and behaviours as the principles of employment and conduct.

Melbourne Health promotes cultural diversity and awareness in the workplace.

Competitive Neutrality

Melbourne Health continues to comply with the Victorian Government's Competitive Neutrality Policy. In addition, the Victorian Government's Competitive Neutrality pricing principles have been applied by Melbourne Health from 1 July 2000 for all relevant business activities.

Safe Patient Care Act 2015

The hospital has no matters to report in relation to its obligations under section 40 of the *Safe Patient Care Act 2015*.

Victorian Industry Participation Policy

Melbourne Health complies with the intent of the *Victorian Industry Participation Policy Act 2003*. The aim of this legislation is to expand market opportunities to Victorian, and Australian organisations and therefore promote employment and business growth in the State.

For tenders and resulting contracts with a value of $3 million or more, Melbourne Health applies VIPP specific evaluation criteria. These criteria assess:

- Level of local content
- Number of newly created or existing jobs retained
- Training, skills development and technology transfer.

The assessment of these criteria in conjunction with other tender specific assessment criteria leads to the selection of the best possible product and service for the expenditure. It also ensures those organisations that provide quality local products and/or services are recognised and promoted as per the policy.

Within the past 12 months, Melbourne Health commenced one metropolitan based contract for which the VIPP applied. This contract was for the provision of work cover services valued at $7,000,000 and was registered with the Industry Capability Network (ICN).

Building Act 1993

Melbourne Health complies wholly with the building and maintenance provisions of the *Building Act 1993.*

Melbourne Health has obtained Building Permits for new projects and Certificates of Occupancy or Certificates of Final Inspection for all completed projects.

Registered Building Practitioners have been involved with all new building works projects and were supervised by either the relevant Construction Manager in liaison with Melbourne Health Capital Projects and/or Independent Project Managers. Each building practitioner has supplied the required Building Registration Number. Building contractors include:

- MAW Building and Maintenance
- Dovagate
- Pirotta
- Davenport & Harrison Pty Ltd
- By Design Pty Ltd
- MRU Constructions
- Arete Australia Pty Ltd

In order to maintain buildings in a safe and serviceable condition, routine inspections were undertaken. Where required, Melbourne Health proceeded to implement the highest priority recommendations arising out of those inspections through planned rectification and maintenance works.

Building certified for approved design phase – under construction

RMH City Campus

- VCCC North Side works including Hybrid theatre & iMRI Theatre – Defect Rectification Works
- Level 6 Roof top garden and Level 7 VCCC Haematology Garden
- PET CT – Level 2 North
- Expansion of Palliative Care
- 1 East Redevelopment – UoM Training, Foundation and SMS Lounge
- Clinical Trials Pharmacy Relocation
- Mode E – Secondary chilled water pumps
- Theatre Expansion Feasibility
- ICU Pandemic Mode
- Relocation Bed Store
- Car Park Extension
- 4th CT Installation
- Familial Cancer Centre refurbishment
- Clinical Trials Centre Redevelopment
- ICU Pod D Redevelopment
- Infrastructure Upgrade Works
- Mammography Install
- CT Ambulance Redevelopment
- Level 8 Stroke Unit Redevelopment
- Cath Lab 1 Replacement

NWMH

- CCU Kitchen Upgrades

RMH Royal Park Campus

- Dialysis Unit

Environmental performance

In 2016/17 we reduced our clinical waste by 65 tonnes through better segregation and increased recycling.

In conjunction with the DHHS, we installed an Organics dehydration unit to process organic waste from the Parkville Precinct into organic fertiliser, diverting the waste from landfill and reducing greenhouse gas emissions.

In October 2016, Melbourne Health was honoured to win the Premier's Sustainability Award in the Health category for the program Reducing Waste, One Dialysis Patient at a Time. Our Nephrology Environmental Sustainability Special Interest Group champions a range of waste reduction initiatives and significantly decreases the amount of waste the service and its patients produce each year.

For more detailed information about our environmental performance, please view our annual Sustainability Report which will be available in October 2017 at **www.thermh.org.au**

Car Parking Fees

Melbourne Health complies with the DHHS hospital circular on car parking fees and details of car parking fees and concession benefits can be viewed at https://www.thermh.org.au/locations

We have paid particular attention over the past 12 months to ensure our concession car parking rates are well publicised through signage and our intranet and website.

Additional Information

Details in respect to the items listed below have been retained by Melbourne Health and are available to the relevant Ministers, Members of Parliament and the public upon request (subject to the Freedom of Information requirements, if applicable):

(a) A statement of pecuniary interest;

(b) Details of shares held by senior officers as nominee or held beneficially in a statutory authority or subsidiary;

(c) Details of publications produced by Melbourne Health about our activities and where they can be obtained;

(d) Details of changes in prices, fees, charges, rates and levies charged by Melbourne Health;

(e) Details of any major external reviews carried out on Melbourne Health;

(f) Details of major research and development activities undertaken by Melbourne Health that are not otherwise covered either in the Report of Operations or in a document that contains the financial report and Report of Operations;

(g) Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit;

(h) Details of major promotional, public relations and marketing activities undertaken to develop community awareness of Melbourne Health and its services;

(i) Details of assessments and measures undertaken to improve the occupational health and safety of employees;

(j) A general statement on industrial relations within the entity and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations;

(k) A list of major committees sponsored by Melbourne Health, the purposes of each committee and the extent to which the purposes have been achieved;

(l) Details of all consultancies and contractors including those engaged, services provided and expenditure committed to for each engagement.

Details of Information and Communication Technology (ICT) expenditure

The total ICT expenditure incurred during 2016/17 is **$20.524 million** (excluding GST) with the details shown below.

DETAILS OF INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) EXPENDITURE ($ MILLION)

Business As Usual (BAU) ICT expenditure (Total)	Non-Business As Usual (non-BAU) ICT expenditure (Total=Operational expenditure and Capital Expenditure)	Operational expenditure	Capital expenditure
$13.892m (excluding GST)	$6.633m (excluding GST)	$0m (excluding GST)	$6.633m (excluding GST)

Details of consultancies (under $10,000)

In 2026/17, there were three consultancies where the total fees payable to the consultants were less than $10,000. The total expenditure incurred during 2016/17 in relation to these consultancies is **$17,374** (excl. GST).

Details of consultancies (valued at $10,000 or greater)

In 2016/17, there were six consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2016/17 in relation to these consultancies is **$518,000** (excl. GST). Details are provided in the below table:

CONSULTANCIES 2016/17

Consultant	Purpose of Consultancy	Start Date	End Date	Total Approved Project Fee (exc. GST) ($'000)	Expenditure 2016/17 (exc. GST) ($'000)	Future Expenditure (exc. GST) ($'000)
Project Health Pty Ltd	Evaluation of Back Assessment and Management Service Mentor Model	1/07/16	30/06/17	13	13	–
Paul W Long Consulting Pty Ltd	Leadership Program Review – Allied Health	1/07/16	30/06/17	28	28	–
Spotless Facility Services Pty Ltd	Support Services Review	1/07/16	30/06/17	28	28	–
MKM Health Pty Limited	IT Resourcing and Capacity Assessment	1/07/16	30/06/17	43	43	–
Paxton Partners	Hospital Admission Risk Program Review	1/07/16	30/06/17	69	69	–
Cognitive Consulting Group Pty Ltd	Safety and Reliability Program	1/07/16	30/09/17	113	113	87
Price Waterhouse Coopers	Establishing Project Management Office	1/07/16	30/06/17	224	224	–

Financial Summary

The key financial performance measure monitored by Melbourne Health Management is the "Net Result before capital and specific items".

In 2016/17 Melbourne Health achieved a small surplus result of $0.3 million which compares favourably with the budgeted breakeven target. It is also an improved result compared to deficit achieved last financial year.

Total Revenue increased $62.9 million from 2015/16 with proportionate increase in expenditure.

MELBOURNE HEALTH FINANCIAL SUMMARY 2016/17

	2017 $'000	2016 $'000	2015 $'000	2014 $'000	2013 $'000
Total Revenue	1,076,114	1,013,192	965,346	913,535	896,883
Total Expenses	1,075,840	1,015,998	966,876	913,236	896,262
Net Result before capital and specific items	274	(2,806)	(1,530)	299	621
Operating Result*					
Capital and Specific Items	(12,956)	(23,382)	(26,717)	3,654	(31,995)
Net Result for the Year	(12,682)	(26,188)	(28,247)	3,953	(31,374)
Retained Surplus / (Deficit)	(207,106)	(192,533)	(160,596)	(127,979)	(159,286)
Total Assets	881,087	849,596	807,832	793,388	626,070
Total Liabilities	340,800	298,610	273,301	284,534	259,880
Net Assets	540,286	550,986	534,531	508,854	366,190
Total Equity	540,286	550,986	534,531	508,854	366,190

*The Operating result is the result for which the hospital is monitored in its Statement of Priorities also referred to as the *Net result before capital and specific items.*

Key Financial & Service Performance Reporting

Statement of Priorities

The Statement of Priorities is the key accountability agreement between Melbourne Health and the Minister for Health. This annual agreement ensures delivery of, or substantial progress towards, the key shared objectives of financial viability, improved access and quality of service provision.

Part A: Strategic Priorities for 2016/17

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Access and timelines	Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Internal review of HARP and Health Independence Program conducted and improvements implemented.	In progress. Independent agency has completed review. Implementation for 2017/18.
		Implementation of PACER initiative at Broadmeadows Inpatient Unit.	Achieved. PACER initiative (joint initiative between Police, Ambulance and early mental health response) implemented at NWAMHS.
		Implementation of expanded post discharge support program across NWMH services.	Achieved. Peer Support Worker strategy operational across NWMH. NWMH to participate in the DHHS led evaluation of this new program.
	Ensure the implementation of a range of strategies in specialist clinics to: • optimise referral management processes and improve patient flow through to ensure patients are seen in turn and within time. • ensure Victorian Integrated Non Admitted Health (VINAH) data accurately reflects the status of waiting patients.	Outpatients transformation project phase 2 activities completed with a focus on using data to improve patient flow through ambulatory services. Waiting list validation will be achieved through the development and implementation of an active clinical audit schedule.	Achieved. Revised follow up process for patients who fail to attend. Structured outpatient waiting list audit schedule in place with audit dashboard in development. Improved data capture and monitoring for VINAH data.
	Ensure the implementation of a range of strategies (including processes and service models) to improve patient flow, transfer times and efficiency in the emergency department, with particular focus on patients who did not wait for treatment and/or patients that re-presented within 48 hours.	Implementation of initiatives that promote a Flexi Bed model by October 2016 to enable the Emergency Department to achieve a NEAT target of 70% by December 2016.	Achieved. Improved discharge planning, flow initiatives and flex bed model helping to achieve a sustained NEAT performance above 70% since December 2016.
	Increase the proportion of patients (locally and across the state) who receive treatment within clinically recommended time for surgery and implement ongoing processes to ensure patients are treated in turn and within clinically recommended timeframes.	Commissioning of two new theatres associated with the VCCC capital project for Melbourne Health including initiatives that support theatre utilisation through the implementation of the Theatre Transformation Project.	Achieved. Both theatres fully commissioned.
		Business cases developed in collaboration with the DHHS to support additional theatre capacity and improved access for time critical stoke patients.	Achieved. Business case submitted to DHHS in December.

Part A: Strategic Priorities for 2016/17 (continued)

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Access and timelines (continued)	Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Engagement with departmental and community agencies during implementation phase in the Northern metropolitan region completed. Establishment of dedicated NDIS resource established to support implementation.	Achieved. NWMH resource appointed to oversee NDIS implementation and impacts to NWMH. Resources developed for NWMH clinical staff at NAMHS.
	Health services develop and implement strategies within their organisation to ensure identification of potential organ and tissue donors and partner with DonateLife Victoria to ensure that all possible donations are achieved.	Implementation and evaluation of the electronic tool (iDeceased) pilot to support increased eye and tissue donations.	Achieved. Implemented and operational; iDeceased is available to all City Campus wards via the intranet.
		Relevant ED and ICU staff to attend DonateLife Victoria organ awareness training.	Achieved. Donate Life organ awareness training attended by ED doctors and ICU staff working towards 100% of their consultants completing the training workshops. Year to date 96% of potential organ donors had a request made to family.
		Organ and Tissue Authority Clinical Practice Improvement Program implemented into hospital services and DonateLife Victoria reporting requirements adhered to.	Achieved. Reporting requirements achieved and performance continues to improve.
Governance, leadership and culture	Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes, leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	Review and evaluation of key clinical governance committees' completed with terms of reference updated and supporting work plans developed.	Achieved. Committee and reporting structure revised with associated revision of terms of reference.
		Sustainable systems developed and implemented to maintain compliance with EQuIP National Standards and to prepare for a change in standards with a focus on credentialing and scope of practice, risk management, leadership capability and development and reporting of complaints.	Achieved. Preparation for Periodic Review in October underway. Self-assessment due to be submitted to ACHS by end August. Priority areas being addressed through governance committees.
		Electronic Medical Record (EMR) planning activities completed to support a funding submission.	Achieved. Business Case completed but unsuccessful in the 2017/18 State Budget. Melbourne Health continues to work closely with the DHHS and the Melbourne Biomedical Precinct partners to progress an EMR.
	Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	Melbourne Health response to VAGO report on Bullying & Harassment implemented together with the DHHS "Pathways to Change" framework.	Achieved. Review complete. All documents updated and communicated to staff via MH Connect. Melbourne Health continues to progress our Cultural Transformation Program which incorporates a focus on positive workplace behaviours.

Part A: Strategic Priorities for 2016/17 (continued)

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Governance, leadership and culture (continued)	Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: • A focus on prevention and the strategies used to manage risks, including the regular review of these controls; and strategies to improve reporting of OHS incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board. • Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	Work place incidence reporting progressed with the implementation of Victorian Health Incident Management System 2.	Not achieved. This state project has been deferred by DHHS, Melbourne Health awaiting further advice.
		Melbourne Health Occupational Violence Plan developed together with a risk management strategy to address occupational violence at work. Risk controls options developed and reviewed in consultation with relevant staff at regular intervals.	Achieved. Occupational Violence framework developed, for Board approval in August 2017.
		Risk management approach to occupational violence and aggression implemented, focusing on identifying additional risk control measures.	Achieved. Operational initiatives to mitigate the risks of occupational violence have been implemented across NWMH and other priority areas.
	Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high-quality and safe person centred care.	Melbourne Health Leadership Framework and programs reviewed, redeveloped and implemented.	Achieved. Audit of leadership programs completed and framework to be finalised in early 2017/18, with a greater focus on how leadership capability programs contribute to succession planning for critical leadership positions.
		Sustainable simulation centre model and mandatory training schedule delivered in alignment with a positive learning culture.	Achieved. Simulation centre model implemented. Mandatory training requirements have been reviewed and new schedules of training have been established for each discipline.
		Melbourne Health Aboriginal Employment Plan reviewed and refreshed.	Achieved. External consultant engaged, report pending. Feedback to be incorporated into the refreshed plan and implemented throughout 2017/18.
	Create a workforce culture that: includes staff in decision making; promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and includes consumers and the community.	Safety Culture element of the Cultural Transformation Program rolled out across Melbourne Health and embedded with a sustainable training and support function developed.	Achieved. 62% of staff participated in Speaking Up for Safety training. A third intake of Safety Champions is in progress which will enable a continued push toward the completion target of 90% by 2019.
		The Melbourne Health Professional Accountability Framework embedded.	Achieved. Continued implementation of weCare system.
		A combined Partnerships in Care & Respecting Our Community Strategies updated and launched.	Achieved. Strategy prepared for 2017–2020 with 3 key goals: 1) Deliver excellent care in partnership with our patients, consumers and carers 2) Engage patients, consumers and carers meaningfully in innovation and research 3) Skill our people in person centred care and shared decision making Associated actions and performance measures are included.

Part A: Strategic Priorities for 2016/17 (continued)

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Governance, leadership and culture (continued)	Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse to children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	Implementation of NWMH FaPMI (Families where a Parent has a Mental Illness) program completed to support identification and appropriate management of children of people with severe mental illness accessing our services.	Achieved. Governance structures for FaPMI program reviewed and new structure to be implemented incorporating FaPMI, gender sensitivity, families as partners in care and diversity.
		All relevant NWMH clinical staff to hold a working with children check.	Achieved. Processes in place for clinical staff to hold a working with children check and is now business as usual.
	Implement policies and procedures to ensure clinical staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	Immunisation procedures and policies reviewed and implemented. Campaign to identify and engage high risk existing staff completed. 'No check no start' program for new starters implemented.	Achieved. Review of high risk staff completed and contacted regarding immunisation requirements. Policies and procedure review completed. New starter program "No check, no start" implemented and transitioned to business as usual.

Part A: Strategic Priorities for 2016/17 (continued)

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Quality and safety	Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who chose to die at home.	Better Care Victoria business case submitted for the 'Responsive Acute Palliative Intervention and Decision Assistance (RAPID ASSIST) Project to enable same day assessment of palliative patients in the community; increase death in venue of patient choice; improve symptom control and management; enhance GP engagement and reduce unplanned hospitalisations.	Achieved. Successful business case submitted and project underway.
		Collaboration with Precinct Partners to develop a precinct wide Palliative Care Model.	Achieved. Precinct wide service in place.
	Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience, and routine data collection.	Refresh of the End of Life Care Program completed by March 2017 with a focus on Goals of Care, futile treatment and advance care planning. Implementation of relevant recommendations by June 2017.	In progress. External review undertaken and plan in development.
	Progress implementation of a whole-of-hospital model for responding to family violence.	In collaboration with the RWH, progress the six key elements of the Strengthening Hospital Responses to Family Violence initiative with a family violence local service model developed and implemented.	Achieved. Organisational wide family violence policies and procedures developed and a multi-year implementation to be undertaken from 2017/18. MH to support smaller health services with implementation.
	Use patient feedback, including the VHES to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	Delivery of person centred improvement projects progressed in response to VHES data. Improvement of VHES discharge related questions achieved to meet DHHS 75% transition index target.	Achieved. Initiative completed – Transition Index of 83%.
		Roll out and completion of an organisational wide project to reduce LOS by 7% that will include implementation of Patient Discharge Information letters; Criteria Driven Discharge (CDD); early identification of Expected Date of Discharge and reduction in variation of LOS for the top fifty conditions.	Achieved. 5.35% reduction in LOS achieved for the 2016/17 financial year, CDD rollout completed and patient discharge letters implemented resulting in improvements in patient discharge experience for Q3.
	Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Safewards program progressed with the establishment of 'Safety' positions in adult and youth inpatient units completed.	Achieved. Safewards Safety positions have been appointed and program is considered part of business as usual.
		Use of restraints monitored in ED following the establishment of a Behavioural Assessment Unit (BAU) by March 2017, resulting in an improvement in the number of admissions to the unit.	Achieved. Mental health patients admitted to the BAU have experienced a reduction in the time to treatment and reduction in restrictive practices.

Part A: Strategic Priorities for 2016/17 (continued)

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Supporting healthy populations	Health services support shared population health and wellbeing planning at a local level – aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	Collaborative framework strategy reviewed in light of PHN priorities and support activities implemented with a focus on hospital attendance/admission prevention by December 2016 and relevant actions implemented by June 2017.	Not Achieved. Deferred.
	That health services focus on primary prevention and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	Progress implementation of the '5 ways to wellbeing' across North West AMHS community.	Achieved. NWAMHS continue to implement across services.
		Immunisation procedures and policies reviewed and implemented.	Achieved. Policies and procedure review completed. New starter program 'No Check, No Start' implemented and transitioned to business as usual.
	Develop and implement strategies that encourage a culturally diverse environment such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Under-represented groups in VHES and Post Discharge Survey identified and feedback response processes reviewed and implemented to best meet needs of culturally diverse communities.	Achieved. Local initiatives completed. Awaiting ATSI report via VHES from over sampling initiative.
		RMH Point Prevalence bedside ward audit completed to include questions relating to interpreter use and preferred language as part of the standard data set.	Achieved. Point prevalence audits replaced with regular nursing practice audits.
	Improve the health outcomes of ATSI people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights.	Data collected and analysed through NAMHS "Experience of care survey" in relation to self-identification of ATSI background. Data utilised to improve promotion of services and access for this community.	Achieved. NAMHS undertaking regular audits for self-identification and feedback obtained through the experience of care survey. NAMHS recruiting to dedicated ATSI position for inpatient unit.
		Feedback and improvement outcomes from NAMHS ATSI project implemented with a focus on the number of consumers accessing the service who identify as ATSI.	Achieved. NAMHS ongoing collaboration with four service providers to grow and embed Aboriginal Health across spectrum of services.
	Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and infrastructure Plan for Victoria's Clinical mental health system.	Leadership and continued involvement provided to the Expert Taskforce on Mental Health and associated working groups. Representation on the Ministerial Advisory Council for Statewide Services and Infrastructure Plan progressed.	Achieved. Executive Director and Carer Advisor positions at NWMH are members of the Ministers Expert Taskforce on Mental Health.
	Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of LGBTI individuals and communities.	Rainbow Quality Guide and Melbourne Health policies and procedures reviewed to ensure they reflect commitment to inclusive practice.	Achieved. Rainbow eQuality actions completed and relevant policies and procedures updated.
		Campaign developed in conjunction with International Day Against Homophobia, Transphobia and Biphobia to promote Melbourne Health as an inclusive health service.	Achieved. Campaign implemented to support International Day Against Homophobia, Transphobia and Biphobia.
	That health services further their engagement with relevant academic institutions and other partners to increase participation in clinical trials.	Clinical trials facility developed and operational by December 2016 to enable commercially sponsored and investigator led clinical trials.	Achieved. Clinical Trials Centre (CTC) opened and fully operational.

Part A: Strategic Priorities for 2016/17 (continued)

DOMAIN	ACTION	DELIVERABLES	OUTCOME
Financial sustainability	Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Cash sustainability strategy and overall cash adequacy review completed in collaboration with DHHS.	Achieved. Annual cash forecast and management strategies developed and implemented.
		Project Management Office (PMO) established and fully operational.	Achieved. PMO established with focus on enhancing project management planning and implementation.
		Financial sustainability plan developed that leverages the April 2016 external independent study and long term viability plan which incorporates RMH sustainability.	Achieved. 5 Year Business Plan completed and approved by MH Executive and Board.
		Next stage of the Financial Shared Services Strategy developed and implemented including Payroll, Accounts Payable, Procurement and Supply Chain and Business Intelligence applications.	Achieved. Acquired RCH Payroll as an additional shared service client. Shared Services now at 25,000 employees for payroll.
		Impact assessment of the VCCC service models on the RMH financial position completed; strategies to address the financial impacts developed and implemented.	Achieved. Impact assessment has been completed and operational management now in place.
	Actively contribute to the development of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Organics processor commissioned and environmental impact report developed.	Achieved. Operating daily since June 2017. To date, has reduced waste by 14.5 tonnes, saved $3,000 and prevented 27.5 tCO2e greenhouse gas emissions.
		Service and master planning and other key activities completed on RMH redevelopment in preparation for the development of a business case.	In progress. Master Planning and Model of Care work progressing in line with DHHS timelines.

Part B: Performance Priorities^

Safety and quality performance

PRIORITY	KEY PERFORMANCE INDICATOR	TARGET	2016/17 RESULT
	Accreditation		
	Compliance with NSQHS Standards accreditation	Full compliance	Achieved
	Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Achieved
	Infection prevention and control		
	CLEANING STANDARD MEASURE	AQL TARGET	OUTCOME
	Overall compliance with cleaning standards	Full compliance	Achieved
	Very high risk (Category A)	90 points	Achieved
	High risk (Category B)	85 points	Achieved
	Moderate risk (Category C)	85 points	Achieved
	Compliance with the Hand Hygiene Australia program	80%	84.2%
	Percentage of healthcare workers immunised for influenza	75%	80.4%
	Patient experience		
	Victorian Healthcare Experience Survey – data submission	Full compliance	Achieved
	Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	88%
	Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	91%
	Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	96%
	Victorian Healthcare Experience Survey – discharge care Quarter 1	75% very positive response	69%
	Victorian Healthcare Experience Survey – discharge care Quarter 2	75% very positive response	71%
	Victorian Healthcare Experience Survey – discharge care Quarter 3	75% very positive response	83%
	Health Associated Infections		
	Number of patients with surgical site infection	No outliers	Achieved
	ICU central line-associated blood stream infection	No outliers	Not achieved
	SAB[1] rate per occupied bed days	< 2/10,000	0.56/1,000
	Mental Health		
	Mental Health – Percentage of adult inpatients who are readmitted within 28 days of discharge	14%	13%
	Mental Health – Rate of seclusion events relating to an acute admission – composite seclusion rate	≤15/1,000	11.76/1,000
	Mental Health – Rate of seclusion events relating to a child and adolescent acute admission	≤15/1,000	25.6/1,000
	Mental Health – Rate of seclusion events relating to an adult acute admission	≤15/1,000	13/1,000
	Mental Health – Rate of seclusion events relating to an aged acute admission	≤15/1,000	2.2/1,000
	Mental Health – Percentage of child and adolescent patients who have post-discharge follow up within seven days	75%	71%*
	Mental Health – Percentage of adult patients who have post-discharge follow-up within seven days	75%	84%*
	Mental Health – Percentage of aged patients who have post-discharge follow-up within seven days	75%	76%*
	Continuing Care		
	Functional independence gain from admission to discharge, relative to length of stay	≥0.39 (GEM) and ≥0.645 (rehab)	0.55 (GEM) and 1.20 (Rehab)

[1] SAB is staphylococcus aureus bacteraemia

* This data may have been affected by industrial activity during the financial year. The collection of nonclinical and administrative data was affected, with impacts on community mental health service activity and client outcome measures.

^ This data should be considered preliminary, with final consolidation to occur 24 August 2017 at 5pm

Part B: Performance Priorities^ (continued)

PRIORITY	KEY PERFORMANCE INDICATOR	TARGET	2016/17 RESULT
Governance, leadership and culture performance	**Culture Performance**		
	People Matter Survey – percentage of staff with a positive response to safety culture questions	80%	89%
Access and timelines	**Emergency care**		
	Percentage of ambulance patients transferred within 40 minutes	90%	80%
	Percentage of Triage Category 1 emergency patients seen immediately	100%	100%
	Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80%	68%
	Percentage of emergency patients with a length of stay less than four hours	81%	68%
	Number of patients with a length of stay in the emergency department greater than 24 hours	0	0
	Elective Surgery		
	Percentage of Urgency Category 1 elective patients removed within 30 days	100%	100%
	Percentage of urgency category 1, 2 and 3 elective patients admitted within clinically recommended timeframes	94%	76%
	20% longest waiting Category 2 and 3 removals from the elective surgery waiting list	100%	99%
	Number of patients on the elective surgery waiting list[2]	2712	2621
	Number of hospital initiated postponements per 100 scheduled admissions	≤8 /100	7.5/100
	Number of patients admitted from the elective surgery waiting list – annual total	9093	9443
	Specialist Clinics		
	Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%	76.8%
	Percentage of routine patients referred by GP or external specialist who attended a first appointment within 365 days	90%	94.8%
Financial sustainability	**Finance**		
	Operating result	$0.0m	0
	Trade creditors	60 days	67
	Patient fee debtors	60 days	58
	Public & private WIES[3] performance to target	100%	104%
	Adjusted Current asset ratio	0.7	0.89
	Days of available cash	14 days	-13.6
	Asset management		
	Basic asset management plan	Full compliance	Full compliance

^ This data should be considered preliminary, with final consolidation to occur 24 August 2017 at 5pm

[2] The target shown is the number of patients on the elective surgery waiting list as at 30 June 2017

[3] WIES is Weighted Inlier Equivalent Separation

Part C: Activity and funding

FUNDING TYPE	2016/17 ACTIVITY ACHIEVEMENT
Acute Admitted	
WIES Public	68,134
WIES Private	15,638
WIES (Public & Private)	**83,772**
WIES DVA	471
WEIS TAC	5,301
WIES TOTAL	**89,554**
Acute Non-Admitted	
Renal Dialysis – Home ABF	123
Total Parenteral Nutrition	159
Home Enteral Nutrition	720
Aged Care	
Residential Aged Care	25,570
Subacute & Non-Acute Admitted	
Subacute WIES – GEM Private	384
Subacute WIES – GEM Public	1,742
Subacute WIES – Palliative Care Private	54
Subacute WIES – Palliative Care Public	210
Subacute WIES – Rehab Private	155
Subacute WIES – Rehab Public	642
Subacute WIES – DVA	35
Transition Care – Beddays	10,121
Transition Care – Homeday	12,068
Subacute Non-Admitted	
Health Independence Program – Public	107,183

FUNDING TYPE	2016/17 ACTIVITY ACHIEVEMENT
Mental Health and Drug Services	
Mental Health Inpatient – Available bed days	74,235
Mental Health Inpatient – Secure Unit	7,906
Mental Health Ambulatory	131,900*
Mental Health Residential	44,528
Mental Health Subacute	10,703

*This data may have been affected by industrial activity during the financial year. The collection of non-clinical and administrative data was affected, with impacts on community mental health service activity and client outcome measures.

Other	
Health Workforce	357

Note: The activity target of 1 for Community Health/Primary Care Programs in the Melbourne Health Statement of Priorities 2016/17 is incorrect. Therefore there is no activity to report against this funding line.

Attestation for Compliance with the Ministerial Standing Direction 3.7.1 – Risk Management Framework and Processes

I, Christine Kilpatrick, certify that Melbourne Health has materially complied with Ministerial Direction 3.7.1 – *Risk Management Framework and Processes*. The Melbourne Health Audit Committee has verified this.

Professor Christine Kilpatrick
Chief Executive

Melbourne
14 August 2017

Attestation on Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

I, Christine Kilpatrick, certify that Melbourne Health has put in place appropriate internal controls and processes to ensure that it has materially complied with all requirements set out in the *HPV Health Purchasing Policies* including mandatory HPV collective agreements as required by the *Health Services Act 1988* (Vic) and has critically reviewed these controls and processes during the year.

Professor Christine Kilpatrick
Chief Executive

Melbourne
14 August 2017

Disclosure Index

The annual report of Melbourne Health is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

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Financial Statements

Melbourne Health Board Member's, Accountable Officer's and Chief Finance & Accounting Officer's Declaration

The attached financial statements for Melbourne Health have been prepared in accordance with Direction 5.2 of the Standing Directions of the Minister for Finance under the *Financial Management Act 1994*, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2017 and the financial position of Melbourne Health at 30 June 2017.

At the time of signing, we are not aware of any circumstance which would render any particulars included in the financial statements to be misleading or inaccurate.

We authorise the attached financial statements for issue on this date.

The Rt Hon Robert Doyle AC
Chairman

Melbourne
14 August 2017

Professor Christine Kilpatrick
Chief Executive

Melbourne
14 August 2017

Mr George Kapitelli
Executive Director
Finance & Logistics

Melbourne
14 August 2017

Independent Audit Report

Independent Auditor's Report

VAGO
Victorian Auditor-General's Office

To the Board of Melbourne Health

Opinion

I have audited the consolidated financial report of Melbourne Health (the health service) and its controlled entities (together the consolidated entity), which comprises the:

- consolidated entity and health service balance sheet as at 30 June 2017
- consolidated entity and health service comprehensive operating statement for the year then ended
- consolidated entity and health service statement of changes in equity for the year then ended
- consolidated entity and health service cash flow statement for the year then ended
- notes to the financial statements, including a summary of significant accounting policies
- board member's, accountable officer's and chief finance & accounting officer's declaration.

In my opinion, the financial report presents fairly, in all material respects, the financial positions of the consolidated entity and the health service as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.

Basis for Opinion

I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. My responsibilities under that Act and those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report.

My independence is established by the *Constitution Act 1975*. My staff and I are independent of the health service and the consolidated entity in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Board's responsibilities for the financial report

The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error.

In preparing the financial report, the Board is responsible for assessing the health service and the consolidated entity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

Level 31 / 35 Collins Street, Melbourne Vic 3000
T 03 8601 7000 enquiries@audit.vic.gov.au www.audit.vic.gov.au

Independent Audit Report (continued)

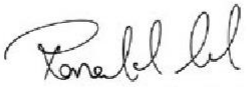
Auditor's responsibilities for the audit of the financial report

As required by the *Audit Act 1994,* my responsibility is to express an opinion on the financial report based on the audit. My objectives for the audit are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the health service and the consolidated entity's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board
- conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the health service and the consolidated entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the health service and the consolidated entity to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation
- obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the health service and consolidated entity to express an opinion on the financial report. I remain responsible for the direction, supervision and performance of the audit of the health service and the consolidated entity. I remain solely responsible for my audit opinion.

I communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.



MELBOURNE
23 August 2017

Ron Mak
as delegate for the Auditor-General of Victoria

2

Melbourne Health Comprehensive Operating Statement

For the Financial Year Ended 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consolidated 2017 $'000	Consolidated 2016 $'000
Revenue from Operating Activities	2.1	1,040,712	978,855	1,041,226	979,002
Revenue from Non-Operating Activities	2.1	7,801	8,267	7,832	8,291
Revenue from Inter Hospital Inventory Sale	2.1	27,057	25,900	27,057	25,900
Employee Expenses	3.1	(756,017)	(704,071)	(756,159)	(704,224)
Non Salary Labour Costs	3.1	(17,030)	(15,206)	(17,030)	(15,206)
Supplies and Consumables	3.1	(167,684)	(163,853)	(167,684)	(163,853)
Other Expenses	3.1	(107,733)	(106,677)	(107,910)	(106,816)
Expenses from Inter Hospital Inventory Purchase	3.1	(27,057)	(25,900)	(27,057)	(25,900)
Net Result Before Capital and Specific Items		**49**	**(2,685)**	**275**	**(2,806)**
Capital Purpose Income	2.1	40,403	33,621	40,403	33,621
Depreciation and Amortisation	3.1, 4.3	(52,334)	(48,574)	(52,336)	(48,574)
Expenditure for Capital Purpose	3.1	(3,921)	(3,461)	(3,921)	(3,461)
Assets Provided Free of Charge	3.3	-	(6,027)	-	(6,027)
Net Result After Capital and Specific Items		**(15,803)**	**(27,126)**	**(15,579)**	**(27,247)**
Other Economic Flows Included in Net Result					
Net gain/(loss) on non-financial assets	8.9	(303)	(130)	(303)	(130)
Net gain/(loss) on financial instruments	8.9	(2,840)	1,189	(2,840)	1,189
Other gains/(losses) from other economic flows	8.9	6,041	-	6,041	-
Total Other Economic Flows Included in Net Result		**2,898**	**1,059**	**2,898**	**1,059**
Net Result From Continuing Operations		**(12,905)**	**(26,067)**	**(12,681)**	**(26,188)**
NET RESULT FOR THE YEAR		**(12,905)**	**(26,067)**	**(12,681)**	**(26,188)**
Other Comprehensive Income					
Changes in Physical Asset Revaluation Surplus	8.1	247	31,521	247	31,521
Changes to Financial Assets Available-for-sale Revaluation Surplus	8.1	-	(1,872)	-	(1,872)
Total Other Comprehensive Income		**247**	**29,649**	**247**	**29,649**
COMPREHENSIVE RESULT FOR THE RESULT		**(12,658)**	**3,582**	**(12,434)**	**3,461**

This Statement should be read in conjunction with the accompanying notes.

Melbourne Health Balance Sheet

As at 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consolidated 2017 $'000	Consolidated 2016 $'000
Current Assets					
Cash and Cash Equivalents	6.2	65,445	52,493	66,012	52,750
Receivables	5.1	74,862	58,294	74,864	58,297
Inventories	5.2	7,926	7,568	7,926	7,568
Prepayments and Other Assets	5.4	38,170	31,402	38,174	31,405
Total Current Assets		**186,403**	**149,757**	**186,976**	**150,020**
Non-Current Assets					
Receivables	5.1	22,681	17,473	22,681	17,473
Investments and Other Financial Assets	4.1	1,154	1,323	1	315
Property, Plant & Equipment	4.2	657,204	679,011	657,206	679,015
Intangible Assets	4.4	14,223	2,773	14,223	2,773
Total Non-Current Assets		**695,262**	**700,580**	**694,111**	**699,576**
TOTAL ASSETS		**881,665**	**850,337**	**881,087**	**849,596**
Current Liabilities					
Payables	5.5	103,537	83,135	102,795	82,421
Borrowings	6.1	412	412	412	412
Provisions	3.4	198,947	180,711	198,958	180,755
Other Liabilities	5.3	1,780	2,782	1,780	2,782
Total Current Liabilities		**304,676**	**267,040**	**303,945**	**266,370**
Non-Current Liabilities					
Borrowings	6.1	6,049	1,539	6,049	1,539
Provisions	3.4	30,801	30,695	30,807	30,701
Total Non-Current Liabilities		**36,850**	**32,234**	**36,856**	**32,240**
TOTAL LIABILITIES		**341,526**	**299,274**	**340,801**	**298,610**
NET ASSETS		**540,139**	**551,063**	**540,286**	**550,986**
EQUITY					
Property, Plant & Equipment Revaluation Surplus	8.1a	332,629	332,382	332,629	332,382
Financial Asset Available for Sale Revaluation Surplus	8.1a	(272)	(272)	-	-
Restricted Specific Purpose Surplus	8.1a	41,393	39,724	41,269	39,377
Contributed Capital	8.1b	373,494	371,760	373,494	371,760
Accumulated Surpluses/(Deficits)	8.1c	(207,105)	(192,531)	(207,106)	(192,533)
TOTAL EQUITY		**540,139**	**551,063**	**540,286**	**550,986**
Commitments	6.3				

This Statement should be read in conjunction with the accompanying notes.

Melbourne Health Statement of Changes in Equity

For the Financial Year Ended 30 June 2017

Consolidated	Note	Property, Plant & Equipment Revaluation Surplus $'000	Financial Asset Available for Sale Revaluation Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributions by Owners $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 1 July 2015		**300,861**	**1,872**	**33,643**	**358,751**	**(160,596)**	**534,531**
Net result for the year	8.1c	-	-	-	-	(26,188)	(26,188)
Other comprehensive income for the year	8.1a	31,521	(1,872)	-	-	-	29,649
Transfer to contributed capital	8.1b	-	-	-	13,009	-	13,009
Transfer to accumulated surplus	8.1a,c	-	-	5,734	-	(5,734)	-
Other - VCCC	8.1c	-	-	-	-	(15)	(15)
Balance at 30 June 2016		**332,382**	**-**	**39,377**	**371,760**	**(192,533)**	**550,986**
Net result for the year	8.1c	-	-	-	-	(12,681)	(12,681)
Other comprehensive income for the year	8.1a	247	-	-	-	-	247
Transfer to contributed capital	8.1b	-	-	-	1,734	-	1,734
Transfer to accumulated surplus	8.1a,c	-	-	1,892	-	(1,892)	-
Balance at 30 June 2017		**332,629**	**-**	**41,269**	**373,494**	**(207,106)**	**540,286**

Parent	Property, Plant & Equipment Revaluation Surplus $'000	Financial Asset Available for Sale Revaluation Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributions by Owners $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 1 July 2015	**300,861**	**1,601**	**33,852**	**358,751**	**(160,594)**	**534,471**
Net result for the year	-	-	-	-	(26,067)	(26,067)
Other comprehensive income for the year	31,521	(1,872)	-	-	-	29,649
Transfer to contributed capital	-	-	-	13,009	-	13,009
Transfer to accumulated surplus	-	(1)	5,872	-	(5,870)	1
Balance at 30 June 2016	**332,382**	**(272)**	**39,724**	**371,760**	**(192,531)**	**551,063**
Net result for the year	-	-	-	-	(12,905)	(12,905)
Other comprehensive income for the year	247	-	-	-	-	247
Transfer to contributed capital	-	-	-	1,734	-	1,734
Transfer to accumulated surplus	-	-	1,669	-	(1,669)	-
Balance at 30 June 2017	**332,629**	**(272)**	**41,393**	**373,494**	**(207,105)**	**540,139**

This Statement should be read in conjunction with the accompanying notes.

Melbourne Health Cash Flow Statement

For the Financial Year Ended 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consolidated 2017 $'000	Consolidated 2016 $'000
CASH FLOWS FROM OPERATING ACTIVITIES					
Operating Grants from Government		810,637	763,791	810,637	763,791
Capital Grants from Government		39,829	33,131	39,829	33,131
Patient and Resident Fees Received		54,501	48,725	54,501	48,725
Private Practice Fees Received		33,183	29,461	33,183	29,461
Donations and Bequests Received		4,231	4,164	4,231	4,164
Capital Donations and Bequests Received		14	6	14	6
GST Received from/(paid to) ATO		28,890	28,417	28,890	28,417
Recoupment from private practice for use of hospital facilities		157	206	157	206
Interest Received		1,819	2,196	1,850	2,221
Dividend Received		148	376	148	376
Other Capital Receipts		357	759	357	759
Other Receipts		134,949	130,699	163,546	160,615
Total Receipts		***1,108,715***	***1,041,931***	***1,137,343***	***1,071,872***
Employee Expenses Paid		(732,329)	(684,809)	(732,504)	(684,955)
Non Salary Labour Costs		(16,914)	(15,166)	(16,914)	(15,166)
Payments for Supplies & Consumables		(170,162)	(166,479)	(196,205)	(190,572)
Other Payments		(139,740)	(142,944)	(141,988)	(148,776)
Total Payments		***(1,059,145)***	***(1,009,398)***	***(1,087,611)***	***(1,039,469)***
NET CASH FLOW FROM/(USED IN) OPERATING ACTIVITIES	8.2	**49,570**	**32,533**	**49,732**	**32,403**
CASH FLOWS FROM INVESTING ACTIVITIES					
Payments for Non-Financial Assets		(42,033)	(55,463)	(42,029)	(55,462)
Purchase of Investments		(145)	(460)	-	(315)
Proceeds from sale of Non-Financial Assets		-	201	-	201
Proceeds from sale of Investments		-	4,788	-	4,788
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		**(42,178)**	**(50,934)**	**(42,029)**	**(50,788)**
CASH FLOWS FROM FINANCING ACTIVITIES					
Proceeds from Borrowings		4,850	90	4,850	90
Repayment of Borrowings		(23)	-	(23)	-
Contributed Capital from Government		1,734	13,008	1,734	13,008
NET CASH FLOW FROM/(USED IN) FINANCING ACTIVITIES		**6,561**	**13,098**	**6,561**	**13,098**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**13,953**	**(5,303)**	**14,264**	**(5,287)**
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		**49,712**	**55,015**	**49,968**	**55,255**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	**63,665**	**49,712**	**64,232**	**49,968**

Notes to and Forming Part of the Financial Statements

Note 1: Basis of presentation

These annual financial statements represent the audited general purpose financial statements for Melbourne Health for the period ending 30 June 2017. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

These financial statements are presented in Australian dollars and the historical cost convention is used unless a different measurement basis is specifically disclosed in the note associated with the item measured on a different basis.

The accrual basis of accounting has been applied in the preparation of these financial statements whereby assets, liabilities, equity, income and expenses are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

Consistent with the requirements of AASB 1004 *Contributions* (that is contributed capital and its repayment) are treated as equity transactions and, therefore, do not form part of the income and expenses of the hospital.

Additions to net assets which have been designated as contributions by owners are recognised as contributed capital.

Other transfers that are in the nature of contributions to or distributions by owners have also been designated as contributions by owners.

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also future periods that are affected by the revision. Judgements and assumptions made by management in applying the application of AASB that have significant effect on the financial statements and estimates are disclosed in the notes under the heading: 'Significant judgement or estimates'.

All amounts in the financial statements have been rounded to the nearest $1,000 unless otherwise stated.

(a) Statement of compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the *Financial Management Act 1994* and applicable AASBs, which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB 101 *Presentation of Financial Statements*.

The financial statements also comply with relevant Financial Reporting Directions (FRDs) issued by the Department of Treasury and Finance and relevant Standing Directions (SDs) authorised by the Minister for Finance.

Melbourne Health is a not-for-profit entity and therefore applies the additional Australian paragraphs applicable to "not-for-profit" entities under the AASBs.

The annual financial statements were authorised for issue by the Board of Melbourne Health on 14 August 2017.

(b) Reporting Entity

The financial statements include all the controlled activities of Melbourne Health.

Its principal address is:

c/o The Royal Melbourne Hospital
Grattan Street, Victoria 3050.

A description of the nature of Melbourne Health's operations and its principal activities is included in the report of operations, which does not form part of these financial statements.

Objectives and funding

Melbourne Health's overall objective is to be *First in Care, Research and Learning* to improve outcomes for our community and Victorians.

Melbourne Health is predominantly funded by accrual based grant funding for the provision of outputs.

Note 1: Basis of presentation (continued)

(c) Basis of accounting preparation and measurement

Accounting policies are selected and applied in a manner which ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2017 and the comparative information presented in these financial statements for the year ended 30 June 2016.

The going concern basis was used to prepare the financial statements.

These financial statements are presented in Australian dollars, the functional and presentation currency of Melbourne Health.

The financial statements, except for cash flow information, have been prepared using the accrual basis of accounting. Under the accrual basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definitions and recognition criteria for those items, that is they are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

The financial statements are prepared in accordance with the historical cost convention, except for:

- Non-current physical assets which, subsequent to acquisition, are measured at revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are re-assessed when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values;
- Available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income); and
- The fair value of assets other than land is generally based on their depreciated replacement value.

In the application of AASBs management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

(d) Principles of Consolidation

In accordance with AASB 10 *Consolidated Financial Statements*:

- The consolidated financial statements of Melbourne Health incorporates the assets and liabilities of all entities controlled by Melbourne Health as at 30 June 2017 and their income and expenses for that part of the reporting period in which control existed.
- The consolidated financial statements exclude bodies of Melbourne Health that are not controlled by Melbourne Health, and therefore are not consolidated.
- Control exists when Melbourne Health has the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable are taken into account.

Where control of an entity is obtained during the financial period, its results are included in the comprehensive operating statement from the date on which control commenced. Where control ceases during a financial period, the entity's results are included for that part of the period in which control existed. Where dissimilar accounting policies are adopted by entities and their effect is considered material, adjustments are made to ensure consistent policies are adopted in these financial statements.

Intersegment Transactions

Transactions between segments within Melbourne Health have been eliminated to reflect the extent of Melbourne Health's operations as a group.

Note 2: Funding delivery of our services

The hospital's overall objective is to deliver programs and services that support and enhance the wellbeing of all Victorians.

To enable the hospital to fulfil its objective it receives income based on parliamentary appropriations. The hospital also receives income from the supply of services.

Structure

2.1 Analysis of revenue by source

Note 2.1: Analysis of revenue by source

	Admitted Patients 2017 $'000	Non-Admitted 2017 $'000	EDs 2017 $'000	Mental Health 2017 $'000	RAC incl. Mental Health 2017 $'000	Aged Care 2017 $'000	Other 2017 $'000	Total 2017 $'000
Government Grant	462,847	12,210	69,558	244,674	11,549	4,543	17,398	822,779
Indirect contributions by Department of Health and Human Services*	3,308	87	497	1,749	83	32	124	5,880
Patient & Resident Fees	30,896	815	4,643	16,332	771	303	1,161	54,921
Commercial Activities	25,810	681	3,879	13,644	644	253	970	45,881
Other Revenue from Operating Activities - S&W Recoveries from External Orgnisations	11,839	312	1,779	6,258	295	116	445	21,044
Other Revenue from Operating Activities	51,032	1,347	7,669	26,977	1,273	503	1,920	90,721
Total Revenue from Operating Activities	**585,732**	**15,452**	**88,025**	**309,634**	**14,615**	**5,750**	**22,018**	**1,041,226**
Interest	1,041	27	156	550	26	10	39	1,849
Dividends	83	2	13	44	2	1	3	148
Other Revenue from Non-Operating Activities	3,282	87	493	1,735	82	32	124	5,835
Total Revenue from Non-Operating Activities	**4,406**	**116**	**662**	**2,329**	**110**	**43**	**166**	**7,832**
Revenue from Inter Hospital Inventory sale	-	-	-	-	-	-	27,057	27,057
Total Revenue from Inter Hospital Inventory Sale	**-**	**-**	**-**	**-**	**-**	**-**	**27,057**	**27,057**
Capital Purpose Income (excluding Interest)	-	-	-	-	-	-	40,403	40,403
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**-**	**-**	**40,403**	**40,403**
Total Revenue	**590,138**	**15,568**	**88,687**	**311,963**	**14,725**	**5,793**	**89,644**	**1,116,518**

	Admitted Patients 2016 $'000	Non-Admitted 2016 $'000	EDs 2016 $'000	Mental Health 2016 $'000	RAC incl. Mental Health 2016 $'000	Aged Care 2016 $'000	Other 2016 $'000	Total 2016 $'000
Government Grant	421,795	11,313	64,498	231,503	13,960	4,178	16,627	763,874
Indirect contributions by Department of Health and Human Services*	4,925	132	753	2,703	163	49	194	8,919
Patient & Resident Fees	29,398	789	4,495	16,135	973	291	1,159	53,240
Commercial Activities	23,151	621	3,540	12,707	766	229	913	41,927
Other revenue from operating activities - S&W Recoveries from external orgnisations	11,932	320	1,825	6,549	395	118	470	21,609
Other Revenue from Operating Activities	49,385	1,324	7,551	27,103	1,634	489	1,947	89,433
Total Revenue from Operating Activities	**540,586**	**14,499**	**82,662**	**296,700**	**17,891**	**5,354**	**21,310**	**979,002**
Interest	1,226	33	188	673	41	12	48	2,221
Dividends	208	6	32	114	7	2	8	377
Other Revenue from Non-Operating Activities	3,144	84	481	1,725	104	31	124	5,693
Total Revenue from Non-Operating Activities	**4,578**	**123**	**701**	**2,512**	**152**	**45**	**180**	**8,291**
Revenue from Inter Hospital Inventory sale	-	-	-	-	-	-	25,900	25,900
Total revenue from Inter Hospital Inventory sale	**-**	**-**	**-**	**-**	**-**	**-**	**25,900**	**25,900**
Capital Purpose Income (excluding Interest)	-	-	-	-	-	-	33,621	33,621
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**-**	**-**	**33,621**	**33,621**
Total Revenue	**545,164**	**14,622**	**83,363**	**299,212**	**18,043**	**5,399**	**81,011**	**1,046,814**

Revenue has been allocated across programs based on percentage of salaries and wages expenditure.

*Department of Health and Human Services makes certain payments on behalf of Melbourne Health (Insurance and Long Service Leave). These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2.1: Analysis of revenue by source (continued)

Income is recognised in accordance with AASB 118 *Revenue* and is recognised as to the extent that it is probable that the economic benefits will flow to Melbourne Health and the income can be reliably measured at fair value. Unearned income at reporting date is reported as income received in advance.

Amounts disclosed as revenue are where applicable, net of returns, allowances and duties and taxes.

Government Grants and other transfers of income (other than contributions by owners)
In accordance with AASB 1004 *Contributions*, government grants and other transfers of income (other than contributions by owners) are recognised as income when Melbourne Health gains control of the underlying assets irrespective of whether conditions are imposed on Melbourne Health's use of the contributions.

Contributions are deferred as income in advance when Melbourne Health has a present obligation to repay them and the present obligation can be reliably measured.

Indirect Contributions from the Department of Health and Human Services

- Insurance is recognised as revenue following advice from the Department of Health and Human Services.
- Long Service Leave (LSL) – Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 04/2017 (updated for 2016–17).

Patient and Resident Fees
Patient and resident fees are recognised as revenue at the time invoices are raised or accrued when a patient is discharged or a service is performed.

Private Practice Fees
Private practice fees are recognised as revenue at the time invoices are raised or accrued.

Revenue from commercial activities
Revenue from commercial activities such as commercial laboratory medicine is recognised at the time invoices are raised.

Donations and Other Bequests
Donations and bequests are recognised as revenue when received. If donations are for a special purpose, they may be appropriated to a surplus, such as the restricted specific purpose surplus.

Dividend Revenue
Dividend revenue is recognised when the right to receive payment is established.

Interest Revenue
Interest revenue is recognised on a time proportionate basis that takes into account the effective yield of the financial asset.

Sale of investments
The gain/loss on the sale of investments is recognised when the investment is realised.

Other income
Other income includes non-property rental, dividends, forgiveness of liabilities, and bad debt reversals.

Category Groups
Melbourne Health has used the following category groups for reporting purposes for the current and previous financial years.

Admitted Patient Services (Admitted Patients) comprises all acute and subacute admitted patient services, where services are delivered in public hospitals.

Non Admitted Services (Non-Admitted) comprises acute and subacute non admitted services, where services are delivered in public hospital clinics and provide models of integrated community care, which significantly reduces the demand for hospital beds and supports the transition from hospital to home in a safe and timely manner.

Emergency Department Services (EDS) comprises all emergency department services.

Mental Health Services (Mental Health) comprises all specialised mental health services providing a range of inpatient, community based residential, rehabilitation and ambulatory services which treat and support people with a mental illness and their families and carers. These services aim to identify mental illness early, and seek to reduce its impact through providing timely acute care services and appropriate longer-term accommodation and support for those living with a mental illness.

Residential Aged Care including Mental Health (RAC incl. Mental Health) referred to in the past as psychogeriatric residential services, comprises those Commonwealth-licensed residential aged care services in receipt of supplementary funding from the department under the mental health program. It excludes all other residential services funded under the mental health program, such as mental health funded community care units and secure extended care units.

Aged Care comprises a range of in home, specialist geriatric, residential care and community based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and their carers.

Other Services not reported elsewhere – (Other) comprises services not separately classified above, including: Public Health Services including laboratory testing, blood borne viruses / sexually transmitted infections clinical services, Koorie liaison officers, immunisation and screening services, drugs services including drug withdrawal, counselling and the needle and syringe program, Disability services including aids and equipment and flexible support packages to people with a disability, Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also falls in this category group.

Note 3: The cost of delivering services

This section provides an account of the expenses incurred by the hospital in delivering services and outputs. In Section 2, the funds that enable the provision of services were disclosed and in this note the cost associated with provision of services are recorded.

Structure

3.1 Analysis of expenses by source

3.2 Analysis of expense and revenue by internally managed and restricted specific purpose funds

3.3 Assets provided free of charge or for nominal consideration

3.4 Employee benefits in the balance sheet

3.5 Superannuation

Note 3.1: Analysis of Expenses by Source

	Admitted Patients 2017 $'000	Non-Admitted 2017 $'000	EDs 2017 $'000	Mental Health 2017 $'000	RAC incl. Mental Health 2017 $'000	Aged Care 2017 $'000	Other 2017 $'000	Total 2017 $'000
Employee Expenses	425,371	11,222	63,925	224,862	10,613	4,176	15,990	756,159
Other Operating Expenses								
Non Salary Labour Costs	9,580	253	1,440	5,064	239	94	360	17,030
Supplies & Consumables	94,329	2,488	14,176	49,865	2,354	926	3,546	167,684
Expenses from Inter Hospital Inventory Purchase	-	-	-	-	-	-	27,057	27,057
Other Expenses	60,704	1,601	9,123	32,091	1,515	595	2,281	107,910
T o tal Expenditure fro m Operating A ctivities	**589 ,984**	**15 ,564**	**88 ,664**	**311,882**	**14 ,721**	**5 ,791**	**49 ,234**	**1,075 ,840**
Other Non-Operating Expenses								
Expenditure for Capital Purposes	-	-	-	-	-	-	3,921	3,921
Depreciation & Amortisation (refer note 4.3)	-	-	-	-	-	-	52,336	52,336
T o tal o ther expenses	**-**	**-**	**-**	**-**	**-**	**-**	**56 ,257**	**56 ,257**
T o tal Expenses	**589 ,984**	**15 ,564**	**88 ,664**	**311,882**	**14 ,721**	**5 ,791**	**105 ,491**	**1,132 ,097**

	Admitted Patients 2016 $'000	Non-Admitted 2016 $'000	EDs 2016 $'000	Mental Health 2016 $'000	RAC incl. Mental Health 2016 $'000	Aged Care 2016 $'000	Other 2016 $'000	Total 2016 $'000
Employee Expenses	388,857	10,430	59,461	213,425	12,870	3,852	15,329	704,224
Other Operating Expenses								
Non Salary Labour Costs	8,397	225	1,284	4,608	278	83	331	15,206
Supplies & Consumables	90,475	2,427	13,835	49,658	2,995	896	3,567	163,853
Expenses from Inter Hospital Inventory Purchase	-	-	-	-	-	-	25,900	25,900
Other Expenses	58,982	1,582	9,019	32,372	1,952	584	2,325	106,816
T o tal Expenditure fro m Operating A ctivities	**546 ,711**	**14 ,664**	**83 ,599**	**300 ,063**	**18 ,095**	**5 ,415**	**47 ,452**	**1,015 ,999**
Other Non-Operating Expenses								
Expenditure for Capital Purposes	-	-	-	-	-	-	3,461	3,461
Assets Provided Free of Charge (refer note 3.3)	-	-	-	-	-	-	6,027	6,027
Depreciation & Amortisation (refer note 4.3)	-	-	-	-	-	-	48,574	48,574
T o tal o ther expenses	**-**	**-**	**-**	**-**	**-**	**-**	**58 ,062**	**58 ,062**
T o tal Expenses	**546 ,711**	**14 ,664**	**83 ,599**	**300 ,063**	**18 ,095**	**5 ,415**	**105 ,514**	**1,074 ,061**

Expense has been allocated across programs based on percentage of salaries and wages expenditure.

Note 3.1: Analysis of Expenses by Source (continued)

Expenses are recognised as they are incurred and reported in the financial year to which they relate.

Employee expenses
Employee expenses include:

- Wages and salaries;
- Leave entitlements;
- Termination payments;
- Workcover premiums; and
- Superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

Other Operating Expenses
Other operating expenses generally represent the day-to-day running costs incurred in normal operations and include:

Supplies and consumables
Supplies and services costs which are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed.

Bad and doubtful debts
Refer to Note 5.1 *Receivables*.

Fair value of assets, services and resources provided free of charge or for nominal consideration
Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another agency as a consequence of a restructuring of administrative arrangements. In the latter case, such a transfer will be recognised at its carrying amount.

Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

Derecognition of financial liabilities
A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

When an existing financial liability is replaced by another from the same lender on substantially different terms, or the terms of an existing liability are substantially modified, such an exchange or modification is treated as a derecognition of the original liability and the recognition of a new liability. The difference in the respective carrying amounts is recognised as an expense in the estimated consolidated comprehensive operating statement.

Leases
A lease is a right to use an asset for an agreed period of time in exchange for payment. Leases are classified at their inception as either operating or finance leases based on the economic substance of the agreement so as to reflect the risks and rewards incidental to ownership.

Leases of property, plant and equipment are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee. All other leases are classified as operating leases.

Operating Leases
Operating lease payments, including any contingent rentals, are recognised as an expense in the comprehensive operating statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset. The leased asset is not recognised in the balance sheet.

Lease Incentives
All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the leased asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are received by the lessee to enter into operating leases, such incentives are recognised as a liability. The aggregate benefits of incentives are recognised as a reduction of rental expense on a straight-line basis, except where another systematic basis is more representative of the time pattern in which economic benefits from the leased asset is diminished.

Note 3.2: Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds

	Expense		Revenue	
	Consolidated 2017 $'000	Consolidated 2016 $'000	Consolidated 2017 $'000	Consolidated 2016 $'000
Commercial Activities				
Private Practice and Other Patient Activities	382	607	429	569
Laboratory Medicine	33	52	240	53
Diagnostic Imaging	891	174	2,333	2,141
Catering	107	227	401	413
Cafeteria	811	895	2,247	2,409
Car Park	1,759	1,546	7,124	6,780
Breastscreen Service	3,990	3,726	3,975	3,821
Mental Health Services	2,507	3,134	3,649	4,528
Medical Special Purpose Funds	19,205	17,445	20,042	18,665
External Supply Agreements	27,057	25,900	27,057	25,900
Other	2,325	1,887	6,273	5,979
Other Activities				
Fundraising and Community Support	16,181	15,430	27,701	24,219
Research and Scholarship	12,243	12,213	13,315	12,918
TOTAL	**87,491**	**83,236**	**114,786**	**108,395**

Note 3.3: Assets provided free of charge or for nominal consideration

	Consolidated 2017 $'000	Consolidated 2016 $'000
During the reporting period, the fair value of assets provided free of charge, was as follows:		
Land	-	1,536
Buildings	-	4,491
TOTAL	**-**	**6,027**

In 2015/16, land and buildings for South Stone Lodge Residential Aged Care Facility which closed during 2014/15 was transferred to Department of Health and Human Services.

Note 3.4: Employee benefits in the balance sheet

	Consolidated 2017 $'000	Consolidated 2016 $'000
Current Provisions		
Employee Benefits		
Annual leave		
- Unconditional and expected to be settled wholly within 12 months [(i)]	44,945	41,566
- Unconditional and expected to be settled wholly after 12 months [(ii)]	7,339	6,915
Long service leave		
- Unconditional and expected to be settled wholly within 12 months [(i)]	12,985	10,548
- Unconditional and expected to be settled wholly after 12 months [(ii)]	83,360	80,877
Other Employee Benefits		
- Unconditional and expected to be settled within 12 months [(i)]	31,034	23,407
	179,663	163,313
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months [(i)]	9,516	8,066
- Unconditional and expected to be settled after 12 months [(ii)]	9,779	9,376
	19,295	17,442
Total Current Provisions	**198,958**	**180,755**
Non-Current Provisions		
Employee Benefits	27,806	27,709
Provisions related to Employee Benefit On-Costs	3,001	2,992
Total Non-Current Provisions	**30,807**	**30,701**
Total Provisions	**229,765**	**211,456**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional LSL Entitlement	106,742	101,190
Annual Leave Entitlements	57,867	53,659
Accrued Wages and Salaries	31,076	22,710
Accrued Days Off	2,263	2,201
Substitution Leave	457	466
Four Clear Days	553	529
Non-Current Employee Benefits and related on costs		
Conditional Long Service Leave Entitlements [(ii)]	30,807	30,701
Total Employee Benefits and Related On-Costs	**229,765**	**211,456**
(b) Movements in provisions		
Movement in Long Service Leave:		
Balance at start of year	131,891	118,580
Provision made during the year		
- Revaluations	(6,041)	4,451
- Expense recognising Employee Service	21,306	18,839
Settlement made during the year	(9,606)	(9,979)
Balance at end of year	**137,550**	**131,891**

(i) The amounts disclosed are nominal amounts.

(ii) The amounts disclosed are discounted to present values.

Note 3.4: Employee benefits in the balance sheet (continued)

Provisions
Provisions are recognised when Melbourne Health has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.

The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation. Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows, using a discount rate that reflects the time value of money and risks specific to the provision.

When some or all of the economic benefits required to settle a provision are expected to be received from a third party, the receivable is recognised as an asset if it is virtually certain that recovery will be received and the amount of the receivable can be measured reliably.

Employee Benefits
This provision arises for benefits accruing to employees in respect of wages and salaries, annual leave and longservice leave for services rendered to the reporting date.

Wages and Salaries, Annual Leave and Accrued Days Off
Liabilities for wages and salaries, including non-monetary benefits and annual leave are all recognised in the provision for employee benefits as 'current liabilities', because the health service does not have an unconditional right to defer settlements of these liabilities.

Depending on the expectation of the timing of settlement, liabilities for wages and salaries, annual leave and sick leave are measured at:

- Undiscounted value – if the health service expects to wholly settle within 12 months; or
- Present value – if the health service does not expect to wholly settle within 12 months.

Long Service Leave (LSL)
The liability for LSL is recognised in the provision for employee benefits.

Unconditional LSL (representing 10 or more years of continuous service) is disclosed in the notes to the financial statements as a current liability even where Melbourne Health does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

- present value – component that Melbourne Health does not expect to settle within 12 months; and
- undiscounted value – component that Melbourne Health expects to settle within 12 months.

Conditional LSL (representing less than 10 years of continuous service) is disclosed as a non-current liability. There is an unconditional right to defer the settlement of the entitlement until the employee has completed the requisite years of service. Conditional LSL is required to be measured at present value.

Any gain or loss followed revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in estimations e.g. bond rate movements, inflation rate movements and changes in probability factors which are then recognised as other economic flow.

Termination Benefits
Termination benefits are payable when employment is terminated before the normal retirement date or when an employee accepts voluntary redundancy in exchange for these benefits.

Liabilities for termination benefits are recognised when a detailed plan for the termination has been developed and a valid expectation has been raised with those employees affected that the terminations will be carried out. The liabilities for termination benefits are recognised in other creditors unless the amount or timing of the payments is uncertain, in which case they are recognised as a provision.

On-costs related to employee expense
Employee benefit on-costs such as payroll tax, workers compensation and superannuation are recognised together with provisions for employee benefits.

Note 3.5: Superannuation

	Paid Contribution for the Year		Contribution Outstanding at Year End		Total Contribution for the Year	
	Consolidated 2017 $'000	Consolidated 2016 $'000	Consolidated 2017 $'000	Consolidated 2016 $'000	Consolidated 2017 $'000	Consolidated 2016 $'000
Defined benefit plans[i]:						
State Superannuation Fund - revised and new	764	769	43	83	807	852
Defined contribution plans:						
VicSuper	777	718	79	77	856	795
HESTA	13,291	12,107	1,605	1,358	14,896	13,465
First State	35,489	36,938	4,298	852	39,787	37,790
Other	2,497	1,543	277	410	2,774	1,953
TOTAL	**52,818**	**52,075**	**6,302**	**2,780**	**59,120**	**54,855**

(i) The basis for determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans.

Employees of Melbourne Health are entitled to receive superannuation benefits and Melbourne Health contributes to both defined benefit and defined contribution plans. The defined benefit plan(s) provides benefits based on years of service and final average salary.

Melbourne Health does not recognise any defined benefit liability in respect of the plan(s) because the entity has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due. The Department of Treasury and Finance discloses the State's defined benefits liabilities in its disclosure for administered items.

However, superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of Melbourne Health.

The names, details and amounts expensed in relation to the major employee superannuation funds and contributions made by Melbourne Health are as follows:

Defined contribution superannuation plans

In relation to defined contribution (i.e. accumulation) superannuation plans, the associated expense is simply the employer contributions that are paid or payable in respect of employees who are members of these plans during the reporting period. Contributions to defined contribution superannuation plans are expensed when incurred.

Defined benefit superannuation plans

The amount charged to the comprehensive operating statement in respect of defined benefit superannuation plans represents the contributions made by the Health Service to the superannuation plans in respect of the services of current Health Service staff during the reporting period. Superannuation contributions are made to the plans based on the relevant rules of each plan, and are based upon actuarial advice.

The name and details of the major employee superannuation funds and contributions made by the Melbourne Health is disclosed in the above table.

Superannuation liabilities

Melbourne Health does not recognise any unfunded defined benefit liability in respect of the superannuation plans because the Health Service has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due.

Note 4: Key Assets to support service delivery

The hospital controls infrastructure and other investments that are utilised in fulfilling its objectives and conducting its activities. They represent the key resources that have been entrusted to the hospital to be utilised for delivery of those outputs.

Structure

4.1 Investments and other financial assets

4.2 Property, plant & equipment

4.3 Depreciation and amortisation

4.4 Intangible assets

Note 4.1: Investments and other financial assets

	Specific Purpose Fund		Consolidated	
	2017 $'000	2016 $'000	2017 $'000	2016 $'000
NON-CURRENT				
Available for sale				
Other				
Shares	1	315	1	315
Total Non-Current	1	315	1	315
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**1**	**315**	**1**	**315**
Represented by:				
Health Service Investments	1	315	1	315
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**1**	**315**	**1**	**315**

(a) Ageing analysis of investments and other financial assets
Please refer to note 7.1(c) for the ageing analysis of investments and other financial assets

(b) Nature and extent of risk arising from investments and other financial assets
Please refer to note 7.1(e) for the nature and extent of credit risk arising from investments and other financial asset

Investments and Other Financial Assets

Hospital investments must be in accordance in Standing Direction 3.7.2 – *Treasury and Investment Risk Management*. Investments are recognised and derecognised on trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned and are initially measured at fair value, net of transaction costs.

Note 4.2: Property, plant & equipment

(a) Gross carrying amount and accumulated depreciation

	Consolidated 2017 $'000	Consolidated 2016 $'000
Land		
Crown Land at Fair Value	98,601	98,601
Freehold Land at Fair Value	63,820	63,820
Total Land	**162,421**	**162,421**
Buildings		
Buildings Under Construction at cost	13,841	11,627
Buildings at Fair Value	490,032	481,746
Less Acc'd Depreciation	100,119	65,957
Leasehold Improvements at cost	5,787	4,595
Less Acc'd Amortisation	2,851	2,320
Total Buildings	**406,690**	**429,691**
Plant and Equipment		
Plant & Equipment Work in Progress	6,332	-
Plant and Equipment at Fair Value	36,140	47,516
Less Acc'd Depreciation	22,493	20,394
Total Plant and Equipment	**19,979**	**27,122**
Medical Equipment		
Medical Equipment Work in Progress	3,425	-
Medical Equipment at Fair Value	130,402	117,387
Less Acc'd Depreciation	75,035	67,094
Total Medical Equipment	**58,792**	**50,293**
Computer Equipment		
Computer Equipment Work in Progress	307	-
Computer Equipment at Fair Value	33,132	30,781
Less Acc'd Depreciation	26,900	24,019
Total Computer Equipment	**6,539**	**6,762**
Furniture & Fittings		
Furniture & Fittings Work in Progress	3	
Furniture & Fittings at Fair Value	3,668	3,257
Less Acc'd Depreciation	2,015	1,754
Total Furniture & Fittings	**1,656**	**1,503**
Motor Vehicles		
Motor Vehicle Assets at Fair Value	1,247	1,553
Less Acc'd Depreciation	118	330
Total Motor Vehicles	**1,129**	**1,223**
TOTAL PROPERTY, PLANT & EQUIPMENT	**657,206**	**679,015**

(b) Reconciliations of the carrying amounts of each class of asset for the consolidated entity at the beginning and end of the previous and current financial year is set out below.

	Land $'000	Buildings $'000	Buildings WIP $'000	Buildings Imps L/Hold $'000	Plant & Equipment $'000	Medical Equipment $'000	Computer Equipment $'000	Furniture & Fittings $'000	Motor Vehicles $'000	Total $'000
Balance at 1 July 2015	**132,436**	**349,850**	**92,154**	**2,592**	**20,351**	**44,018**	**4,180**	**912**	**1,010**	**647,503**
Additions	-	4,360	17,409	106	19,116	8,814	3,844	243	635	54,527
Disposals	-	-	-	-	(11)	(190)	(1)	-	(129)	(331)
Assets Provided Free of Charge	(1,536)	(4,491)	-	-	-	-	-	-	-	(6,027)
Revaluation Increments/(Decrements)	31,521	-	-	-	-	-	-	-	-	31,521
Net Transfers between Classes	-	99,484	(97,936)	20	(10,536)	6,583	1,791	558	-	(36)
Depreciation and Amortisation (note 4.3)	-	(33,414)	-	(443)	(1,798)	(8,932)	(3,052)	(210)	(293)	(48,142)
Balance at 1 July 2016	**162,421**	**415,789**	**11,627**	**2,275**	**27,122**	**50,293**	**6,762**	**1,503**	**1,223**	**679,015**
Additions	-	2,811	8,886	34	11,343	14,457	3,286	407	21	41,245
Disposals	-	-	-	-	(3)	(285)	(10)	-	(5)	(303)
Assets Provided Free of Charge	-	-	-	-	-	-	-	-	-	-
Revaluation Increments/(Decrements)	-	-	-	-	-	-	-	-	247	247
Net Transfers between Classes	-	5,457	(6,672)	1,177	(16,316)	4,067	277	9	17	(11,984)
Depreciation and Amortisation (note 4.3)	-	(34,144)	-	(550)	(2,167)	(9,740)	(3,776)	(263)	(374)	(51,014)
Balance at 30 June 2017	**162,421**	**389,913**	**13,841**	**2,936**	**19,979**	**58,792**	**6,539**	**1,656**	**1,129**	**657,206**

Land and buildings carried at valuation

An independent valuation of Melbourne Health's land and buildings was performed by the Valuer-General Victoria to determine the fair value of the land and buildings. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the valuation is 30 June 2014.

In June 2016, a managerial revaluation of land asset class was undertaken by Melbourne Health in accordance with FRD103F *Non-Current Physical Assets* by using indices published by DTF from the VGV as approved by the DHHS. The effective date of the valuation was 30 June 2016.

Note 4.2: Property, plant & equipment (continued)

Property, plant and equipment
All non-current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and accumulated impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/ machinery of government are transferred at their carrying amount.

Crown Land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

Land and Buildings are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and accumulated impairment loss.

Plant, equipment and vehicles are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and accumulated impairment loss. Depreciated historical cost is generally a reasonable proxy for fair value because of the short lives of the assets concerned.

Leasehold Improvements
The cost of a leasehold improvement is capitalised as an asset and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the improvements.

Revaluations of non-current physical assets
Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103F *Non-current physical assets*. This revaluation process normally occurs at least every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

Revaluation increments are recognised in 'other comprehensive income' and are credited directly in equity to the asset revaluation surplus, except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously recognised as an expense in net result, the increment is recognised as income in the net result.

Revaluation decrements are recognised in 'other comprehensive income' to the extent that a credit balance exists in the asset revaluation surplus in respect of the same class of property, plant and equipment.

Revaluation increases and revaluation decreases relating to individual assets within an asset class are offset against one another within that class but are not offset in respect of assets in different classes.

Revaluation surplus is not transferred to accumulated funds on derecognition of the relevant asset.

In accordance with FRD 103F, Melbourne Health's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Note 4.2: Property, plant & equipment (continued)

(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using: Level 1 [i]	Level 2 [i]	Level 3 [i]
Land at fair value				
Non-specialised land	63,820	-	-	63,820
Specialised land				
- Crown land	98,601	-	-	98,601
Total of land at fair value	162,421	-	-	162,421
Buildings at fair value				
Specialised buildings	389,913	-	-	389,913
Total of building at fair value	389,913	-	-	389,913
Plant and equipment at fair value				
Plant and equipment at fair value	13,647	-	-	13,647
Total of plant and equipment at fair value	13,647	-	-	13,647
Medical equipment at fair value				
Medical equipment at fair value	55,367	-	-	55,367
Total medical equipment at fair value	55,367	-	-	55,367
Computer equipment at fair value				
Computer equipment at fair value	6,232	-	-	6,232
Total computer equipment at fair value	6,232	-	-	6,232
Furniture & Fittings at fair value				
Furniture & Fittings at fair value	1,653	-	-	1,653
Total furniture & fittings at fair value	1,653	-	-	1,653
Motor vehicles at fair value				
Motor vehicles at fair value	1,129	-	1,129	-
Total motor vehicles at fair value	1,129	-	1,129	-
	630,362	**-**	**1,129**	**629,233**

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using: Level 1 [i]	Level 2 [i]	Level 3 [i]
Land at fair value				
Non-specialised land	63,820	-	-	63,820
Specialised land				
- Crown land	98,601	-	-	98,601
Total of land at fair value	162,421	-	-	162,421
Buildings at fair value				
Specialised buildings	415,789	-	-	415,789
Total of building at fair value	415,789	-	-	415,789
Plant and equipment at fair value				
Plant and equipment at fair value	11,936	-	-	11,936
Total of plant and equipment at fair value	11,936	-	-	11,936
Medical equipment at fair value				
Medical equipment at fair value	50,293	-	-	50,293
Total medical equipment at fair value	50,293	-	-	50,293
Computer equipment at fair value				
Computer equipment at fair value	6,762	-	-	6,762
Total computer equipment at fair value	6,762	-	-	6,762
Furniture & Fittings at fair value				
Furniture & Fittings at fair value	1,503	-	-	1,503
Total furniture & fittings at fair value	1,503	-	-	1,503
Motor vehicles at fair value				
Motor vehicles at fair value	1,223	-	1,223	-
Total motor vehicles at fair value	1,223	-	1,223	-
	649,927	**-**	**1,223**	**648,704**

[i] Classified in accordance with the fair value hierarchy.
There have been no transfers between levels during the period.

Note 4.2: Property, plant & equipment (continued)

Consistent with AASB 13 *Fair Value Measurement*, Melbourne Health determines the policies and procedures for both recurring fair value measurements such as property, plant and equipment, investment properties and financial instruments, and for non-recurring fair value measurements such as non-financial physical assets held for sale, in accordance with the requirements of AASB 13 and the relevant FRDs.

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy, described as follows, based on the lowest level input that is significant to the fair value measurement as a whole:

- Level 1 – Quoted (unadjusted) market prices in active markets for identical assets or liabilities.
- Level 2 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable.
- Level 3 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

For the purpose of fair value disclosures, Melbourne Health has determined classes of assets and liabilities on the basis of the nature, characteristics and risks of the asset or liability and the level of the fair value hierarchy as explained above.

In addition, Melbourne Health determines whether transfers have occurred between levels in the hierarchy by reassessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period.

The Valuer-General Victoria (VGV) is Melbourne Health's independent valuation agency.

Melbourne Health, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required.

(d) Reconciliation of Level 3 fair value

	Land $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000	Computer Equipment $'000	Furniture & Fittings $'000
Balance at 1 July 2015	**132,436**	**349,850**	**7,579**	**44,018**	**4,180**	**912**
Purchases (sales)	-	4,360	873	8,814	3,844	243
Transfer between classes (within Level 3)	-	99,484	5,293	6,583	1,791	558
Gains or losses recognised in net result						
- Depreciation	-	(33,414)	(1,798)	(8,932)	(3,052)	(210)
- Disposals	(1,536)	(4,491)	(11)	(190)	(1)	-
Subtotal	(1,536)	(37,905)	(1,809)	(9,122)	(3,053)	(210)
Items recognised in other comprehensive income						
- Revaluation	31,521	-	-	-	-	-
Subtotal	31,521	-	-	-	-	-
Balance at 1 July 2016 [(i)]	**162,421**	**415,789**	**11,936**	**50,293**	**6,762**	**1,503**
Purchases (sales)	-	2,809	1,598	13,562	3,246	368
Transfer between classes (within Level 3)	-	5,457	2,283	1,537	10	45
Gains or losses recognised in net result						
- Depreciation	-	(34,142)	(2,167)	(9,740)	(3,776)	(263)
- Disposals	-	-	(3)	(285)	(10)	-
Subtotal	-	(34,142)	(2,170)	(10,025)	(3,786)	(263)
Items recognised in other comprehensive income						
- Revaluation	-	-	-	-	-	-
Subtotal	-	-	-	-	-	-
Balance at 30 June 2017 [(i)]	**162,421**	**389,913**	**13,647**	**55,367**	**6,232**	**1,653**

There have been no transf ers betw een levels during the period.

(i) Excludes assets under construction and leashold assets.

Note 4.2: Property, plant & equipment (continued)

(e) Fair value determination

Asset class	Fair value level	Valuation approach	Significant inputs (Level 3 only)
Non-specialised land	Level 3	Market approach	Community Service Obligation (CSO) adjustment
Specialised land	Level 3	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings	Level 3	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings
Plant and equipment at fair value	Level 3	Depreciated replacement cost	Cost per unit Useful life of PPE
Medical equipment at fair value	Level 3	Depreciated replacement cost	Cost per unit Useful life of medical equipment
Computer equipment at fair value	Level 3	Depreciated replacement cost	Cost per unit Useful life of computer equipment
Furnitures & fittings at fair value	Level 3	Depreciated replacement cost	Cost per unit Useful life of furnitures & fittings
Motor vehicles at fair value	Level 2	Market approach	

The significant inputs have remained unchanged from 2016.

Non-specialised land and non-specialised buildings

Non-specialised land and non-specialised buildings are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value.

For non-specialised land and non-specialised buildings, an independent valuation was performed by independent valuers Urbis Valuations Pty Ltd to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014.

To the extent that non-specialised land and non-specialised buildings do not contain significant, unobservable adjustments, these assets are classified as Level 2 under the market approach.

Specialised land and specialised buildings

The market approach is also used for specialised land and specialised buildings although is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued. Specialised assets contain significant, unobservable adjustments; therefore these assets are classified as Level 3 under the market based direct comparison approach.

The CSO adjustment is a reflection of the valuer's assessment of the impact of restrictions associated with an asset to the extent that is also equally applicable to market participants. This approach is in light of the highest and best use consideration required for fair value measurement, and takes into account the use of the asset that is physically possible, legally permissible and financially feasible.

As adjustments of CSO are considered as significant unobservable inputs, specialised land would be classified as Level 3 assets.

The depreciated replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation. As depreciation adjustments are considered as significant and unobservable inputs in nature, specialised buildings are classified as Level 3 for fair value measurements.

An independent valuation of Melbourne Health's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2014.

Vehicles

Melbourne Health acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by Melbourne Health. Vehicles are compared to market values annually and accounted for accordingly at fair value.

Plant and equipment

Plant and equipment is held at carrying amount (depreciated cost). When plant and equipment is specialised in use, such that it is rarely sold other than as part of a going concern, the depreciated replacement cost is used to estimate the fair value. Unless there is market evidence that current replacement costs are significantly different from the original acquisition cost, it is considered unlikely that depreciated replacement cost will be materially different from the existing carrying amount.

There were no changes in valuation techniques throughout the period to 30 June 2017.

For all assets measured at fair value, the current use is considered the highest and best use.

Note 4.3: Depreciation and amortisation

	Consolidated 2017 $'000	Consolidated 2016 $'000
Depreciation		
Buildings	34,144	33,414
Plant & Equipment	2,167	1,798
Medical Equipment	9,740	8,932
Computer Equipment	3,776	3,052
Furniture & Fittings	263	210
Motor Vehicles	374	293
Total Depreciation	**50,464**	**47,699**
Amortisation		
Leased Assets	550	443
Intangible Assets	1,322	432
Total Amortisation	**1,872**	**875**
Total Depreciation & Amortisation	**52,336**	**48,574**

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (i.e. excludes land, assets held for sale, and investment properties). Depreciation begins when the asset is available for use, which is when it is in the location and condition necessary for it to be capable of operating in a manner intended by management.

Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives, residual value and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health and Human Services. Assets with a cost in excess of $1,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

The following table indicates the expected useful lives of non-current assets on which the depreciation charges are based.

	2017	2016
Buildings		
- Structure Shell Building Fabric	5 to 52 years	5 to 52 years
- Site Engineering Services and Central Plant	3 to 32 years	3 to 32 years
Central Plant		
- Fit Out	2 to 25 years	2 to 25 years
- Trunk Reticulated Building Systems	1 to 22 years	1 to 22 years
Plant & Equipment	10 years	10 years
Medical Equipment	10 years	10 years
Computers and Communication	3 years	3 years
Furniture and Fitting	10 years	10 years
Motor Vehicles	4 years	4 years
Intangible Assets	3 years	3 years
Leasehold Improvements	2 to 10 Years	2 to 10 Years

As part of the buildings valuation, building values were componentised and each component assessed for its useful life which is represented above.

Note 4.4: Intangible assets

	Consolidated 2017 $'000	Consolidated 2016 $'000
Capitalised Costs	16,283	16,243
Less Acc'd Amortisation	14,529	13,990
	1,754	**2,253**
Post Office License	70	70
	70	**70**
Software Costs Capitalised	26,945	14,213
Less Acc'd Amortisation	14,546	13,763
	12,399	**450**
Total Intangible Assets	**14,223**	**2,773**

Reconciliation of the carrying amounts of intangible assets at the beginning and end of the previous and current financial year:

	Capitalised Costs $'000	Software Costs Capitalised $'000	Post Office License $'000	Total $'000
Balance at 1 July 2015	**1,704**	**457**	**70**	**2,231**
Additions	653	285	-	938
Net Transfers between Classes	39	(3)	-	36
Amortisation (note 4.3)(i)	(143)	(289)	-	(432)
Balance at 1 July 2016	**2,253**	**450**	**70**	**2,773**
Additions	40	746	-	786
Net Transfers between Classes	-	11,986	-	11,986
Amortisation (note 4.3)(i)	(539)	(783)	-	(1,322)
Balance at 30 June 2017	**1,754**	**12,399**	**70**	**14,223**

(i) The consumption of separately acquired intangible assets is included in the 'amortisation' line item, w here the consumption of the internally generated intangible assets is included in 'net gain/(loss) on non-financial assets' line item on the comprehensive operating statement.

Note 4.4: Intangible assets (continued)

Intangible Assets
Intangible assets represent identifiable non-monetary assets without physical substance such as patents, trademarks, and computer software and development costs (where applicable).

Intangible assets are initially recognised at cost. Subsequently, intangible assets with finite useful lives are carried at cost less accumulated amortisation and accumulated impairment losses. Costs incurred subsequent to initial acquisition are capitalised when it is expected that additional future economic benefits will flow to Melbourne Health.

When the recognition criteria in AASB 138 *Intangible Assets* are met, internally generated intangible assets are recognised and measured at cost less accumulated depreciation/amortisation and impairment.

An internally-generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

a. the technical feasibility of completing the intangible asset so that it will be available for use or sale;

b. an intention to complete the intangible asset and use or sell it;

c. the ability to use or sell the intangible asset;

d. the intangible asset will generate probable future economic benefits;

e. the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and

f. the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Intangible produced assets with finite lives are depreciated as an expense on a systematic basis over the asset's useful life.

Amortisation
Amortisation is allocated to intangible assets with finite useful lives on a systematic (typically straight-line) basis over the asset's useful life. Amortisation begins when the asset is available for use, that is, when it is in the location and condition necessary for it to be capable of operating in the manner intended by management.

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the asset concerned is tested as to whether its carrying value exceeds its recoverable amount.

Intangible assets with indefinite useful lives are not amortised, but are tested for impairment annually or whenever there is an indication that the asset may be impaired. The useful lives of intangible assets that are not being amortised are reviewed each period to determine whether events and circumstances continue to support an indefinite useful life assessment for that asset. In addition, Melbourne Health tests all intangible assets with indefinite useful lives for impairment by comparing the recoverable amount for each asset with its carrying amount:

- annually; and
- whenever there is an indication that the intangible asset may be impaired.

Any excess of the carrying amount over the recoverable amount is recognised as an impairment loss.

Intangible assets with finite useful lives are amortised over a 3 year period.

Note 5: Other assets and liabilities

This section sets out those assets and liabilities that arose from the hospital's operations.

Structure

5.1 Receivables

5.2 Inventories

5.3 Other liabilities

5.4 Prepayments and other assets

5.5 Payables

Note 5.1: Receivables

	Consolidated 2017 $'000	Consolidated 2016 $'000
CURRENT		
Contractual		
Inter Hospital Debtors	13,218	14,246
Trade Debtors	35,858	19,215
Patient Fees	13,493	14,624
Accrued Investment Income	141	173
Accrued Revenue - Other	9,010	8,414
Less Allowance for Doubtful Debts		
Trade Debtors	(348)	(246)
Patient Fees	(1,419)	(2,016)
	69,953	**54,410**
Statutory		
GST Receivable	4,911	3,887
	4,911	**3,887**
TOTAL CURRENT RECEIVABLES	**74,864**	**58,297**
NON-CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	22,681	17,473
TOTAL NON-CURRENT RECEIVABLES	**22,681**	**17,473**
TOTAL RECEIVABLES	**97,545**	**75,770**

Note 5.1: Receivables (continued)

(a) Movement in the Allowance for doubtful debts

	Consolidated 2017 $'000	Consolidated 2016 $'000
Balance at beginning of year	2,262	1,407
Amounts written off during the year	(2,139)	(1,093)
Increase/(decrease) in allowance recognised in net result	1,644	1,948
Balance at end of year	**1,767**	**2,262**

(b) Ageing analysis of receivables

Please refer to note 7.1(c) for the ageing analysis of contractual receivables

(c) Nature and extent of risk arising from receivables

Please refer to note 7.1(e) for the nature and extent of credit risk arising from contractual receivables

Receivables consist of:

- contractual receivables, which includes mainly debtors in relation to goods and services and accrued investment income.
- statutory receivables, which includes predominantly amounts owing from the Victorian Government and GST input tax credits recoverable.

Receivables that are contractual are classified as financial instruments and categorised as loans and receivables.

Statutory receivables are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments because they do not arise from a contract.

Receivables are recognised initially at fair value and subsequently measured at amortised cost, using the effective interest method, less any accumulated impairment.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition. Collectability of debts is reviewed on an ongoing basis, and debts which are known to be uncollectible are written off. A provision for doubtful debts is recognised when there is objective evidence that the debts may not be collected and bad debts are written off when identified.

Doubtful debts

Receivables are assessed for bad and doubtful debts on a regular basis. Those bad debts considered as written off by mutual consent are classified as a transaction expense. Bad debts not written off by mutual consent and the allowance for doubtful debts are classified as other economic flows in the net result.

Note 5.2: Inventories

	Consolidated 2017 $'000	Consolidated 2016 $'000
Pharmaceuticals*		
At cost	2,195	2,499
Supply Store*		
At cost	2,259	1,629
Aids and Appliance*		
At cost	72	79
Medical and Surgical Lines*		
At cost	2,591	2,486
Pathology*		
At cost	809	875
TOTAL INVENTORIES	**7,926**	**7,568**

* All categories are valued at the low er of Cost and/or Net Realisable Value.

Inventories include goods and other property held either for sale, consumption or for distribution at no or nominal cost in the ordinary course of business operations. It excludes depreciable assets.

Inventories held for distribution are measured at cost, adjusted for any loss of service potential. All other inventories, including land held for sale, are measured at the lower of cost and net realisable value.

Inventories acquired for no cost or nominal considerations are measured at current replacement cost at the date of acquisition.

The basis used in assessing loss of service potential for inventories held for distribution include current replacement cost and technical or functional obsolescence. Technical obsolescence occurs when an item still functions for some or all of the tasks it was originally acquired to do but no longer matches existing technologies. Functional obsolescence occurs when an item no longer functions the way it did when it was first acquired.

Cost for inventory is measured on the basis of weighted average cost.

Note 5.3: Other liabilities

	Consolidated 2017 $'000	Consolidated 2016 $'000
CURRENT		
Monies Held in Trust		
- Patient Monies Held in Trust	174	175
- Accommodation Bonds (Refundable Entrance Fees)	1,606	2,607
Total Current	**1,780**	**2,782**
Total Other Liabilities	**1,780**	**2,782**
Total Monies Held in Trust		
Represented by the following assets:		
Cash Assets (refer to Note 6.2)	1,780	2,782
TOTAL	**1,780**	**2,782**

Note 5.4: Prepayments and Other Assets

CURRENT	Consolidated 2017 $'000	Consolidated 2016 $'000
Prepayments	38,174	31,405
TOTAL CURRENT OTHER ASSETS	**38,174**	**31,405**

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

Note 5.5: Payables

	Consolidated 2017 $'000	Consolidated 2016 $'000
CURRENT		
Contractual		
Trade Creditors	56,843	46,120
Income in Advance	11,682	7,741
Accrued Expenses	23,546	19,507
Salary Packaging	3,055	3,121
Other	2,518	1,475
	97,644	**77,964**
Statutory		
GST Payable	1,418	990
PAYG Withholding	3,733	3,467
	5,151	**4,457**
TOTAL CURRENT	**102,795**	**82,421**
TOTAL PAYABLES	**102,795**	**82,421**

(a) Maturity analysis of payables
Please refer to Note 7.1(d) for the ageing analysis of contractual payables.

(b) Nature and extent of risk arising from payables
Please refer to note 7.1(e) for the nature and extent of risks arising from contractual payables.

Payables consist of:

- contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to Melbourne Health prior to the end of the financial year that are unpaid, and arise when Melbourne Health becomes obliged to make future payments in respect of the purchase of those goods and services. The normal credit terms for accounts payable are usually Nett 30 days.
- statutory payables, such as goods and services tax and fringe benefits tax payables.

Contractual payables are classified as financial instruments and are initially recognised at fair value, and then subsequently carried at amortised cost. Statutory payables are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from a contract.

Note 6: How we finance our operations

This section provides information on the sources of finance utilised by the hospital during its operations, along with interest expenses (the cost of borrowings) and other information related to financing activities of the hospital.

This section includes disclosures of balances that are financial instruments (such as borrowings and cash balances).

Note: 7.1 provides additional, specific financial instrument disclosures.

Structure

6.1 Borrowings

6.2 Cash and cash equivalents

6.3 Commitments for expenditure

Note 6.1: Borrowings

	Consolidated 2017 $'000	Consolidated 2016 $'000
CURRENT		
- Advances from Department of Health and Human Services (i)	412	412
Total Australian Dollars Borrowings	**412**	**412**
Total Current	**412**	**412**
NON CURRENT		
Australian Dollar Borrowings		
- Advances from Department of Health and Human Services (i)	6,049	1,539
Total Australian Dollars Borrowings	**6,049**	**1,539**
Total Non-Current	**6,049**	**1,539**
Total Borrowings	**6,461**	**1,951**

(i) The Department of Health and Human Services has provided Melbourne Health with the following three loans:
a) A loan to implement a Laboratory Information System for its Pathology Department. The loan is repayable over five years commencing from June 2018.
b) A loan for management of organic waste as part of a Victorian Government initiative to divert organic waste from general waste. The loan is repayayable over four years commencing from May 2017.
c) A loan for new enterprise billing system. The loan is repayable over five years commencing from July 2018.

All three loans are interest free loans. However, a present value calculation is required as payments are to be made in future financial years.

(a) Maturity analysis of borrowings
Please refer to note 7.1(d) for the ageing analysis of borrowings.

(b) Nature and extent of risk arising from borrowings
Please refer to note 7.1(e) for the nature and extent of risks arising from borrowings.

(c) Defaults and breaches
During the current and prior year, there were no defaults and breaches of any of the borrowings.

All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs. The measurement basis subsequent to initial recognition depends on whether Melbourne Health has categorised its borrowings as either, financial liabilities designated at fair value through profit or loss, or financial liabilities at amortised cost. Any difference between the initially recognised amount and the redemption value is recognised in net result over the period of the borrowing using the effective interest method.

The classification depends on the nature and purpose of the borrowing. Melbourne Health determines the classification of its borrowing at initial recognition.

Note 6.2: Cash and cash equivalents

For the purposes of the cash flow statement, cash assets includes cash on hand and at banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value.

	Consolidated 2017 $'000	Consolidated 2016 $'000
Cash on Hand	40	41
Cash at Bank	64,192	49,927
Other		
- Patient Trust Monies	1,780	2,782
Total Cash and Cash Equivalents	**66,012**	**52,750**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	64,232	49,968
Cash for Monies Held in Trust	1,780	2,782
Total Cash and Cash Equivalents	**66,012**	**52,750**

Cash and cash equivalents recognised on the balance sheet comprise cash on hand and cash at bank, deposits at call and highly liquid investments (with an original maturity of three months or less), which are held for the purpose of meeting short term cash commitments rather than for investment purposes, which are readily convertible to known amounts of cash with an insignificant risk of changes in value.

Note 6.3: Commitments for expenditure

a) Commitments other than public private partnerships

	Consolidated 2017 $'000	Consolidated 2016 $'000
Capital Expenditure Commitments		
Payable:		
Land and Buildings	14,745	8,664
Plant and Equipment	24,761	17,081
Intangible Assets	6,540	10,000
Total capital expenditure commitments	**46,046**	**35,745**
Other Expenditure Commitments		
Payable:		
Contracted Services	140,607	69,404
Total other expenditure commitments	**140,607**	**69,404**
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	90,109	83,813
Total lease commitments	**90,109**	**83,813**
Operating Leases		
Non-cancellable	90,109	83,813
Sub Total	**90,109**	**83,813**
Total operating lease commitments	**90,109**	**83,813**
Total Commitments (inclusive of GST) other than public private partnerships	**276,762**	**188,962**

All amounts shown in the commitments note are nominal amounts inclusive of GST.

(b) Commitments payable

	2017 $'000	2016 $'000
Capital expenditure commitments payable		
Less than 1 year	44,949	33,746
Longer than 1 year but not longer than 5 years	1,097	1,999
Total capital expenditure commitments	**46,046**	**35,745**
Other expenditure commitments payable		
Less than 1 year	64,411	31,318
Longer than 1 year but not longer than 5 years	71,692	38,063
5 years or more	4,504	23
Total other expenditure commitments	**140,607**	**69,404**
Lease commitments payable		
Less than 1 year	9,924	8,438
Longer than 1 year but not longer than 5 years	27,885	21,191
5 years or more	52,300	54,184
Total lease commitments	**90,109**	**83,813**
Total commitments (inclusive of GST)	**276,762**	**188,962**
Less GST recoverable from the Australian Tax Office	(25,160)	(17,178)
Total commitments (exclusive of GST)	**251,602**	**171,784**

All amounts shown in the commitments note are nominal amounts.

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note at their nominal value and are inclusive of the GST payable. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

Note 7: Risks, contingencies & valuation uncertainties

Sensitivity Disclosure Analysis

The hospital is exposed to risk from its activities and outside factors. In addition, it is often necessary to make judgements and estimates associated with recognition and measurement of items in the financial statements. This section sets out financial instrument specific information, (including exposures to financial risks) as well as those items that are contingent in nature or require a higher level of judgement to be applied, which for the hospital is related mainly to fair value determination.

Structure

7.1 Financial instruments

Note 7.1: Financial instruments

(a) Financial risk management objectives and policies

Melbourne Health's principal financial instruments comprise of:

- Cash Assets
- Receivables (excluding statutory receivables)
- Payables (excluding statutory payables)
- Patient Trust Accounts
- Accommodation Bonds

The main purpose in holding financial instruments is to prudentially manage Melbourne Health's financial risks within the government policy parameters.

Categorisation of financial instruments

2017	Contractual financial assets - loans and receivables $'000	Contractual financial assets - available for sale $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets				
Cash and Cash Equivalents	66,012	-	-	66,012
Receivables				
- Trade Debtors	35,510	-	-	35,510
- Other Receivables	34,443	-	-	34,443
Other Financial Assets				
- Shares in Other Entities	-	1	-	1
Total Financial Assets (i)	**135,965**	**1**	**-**	**135,966**
Financial Liabilities				
Payables	-	-	97,644	97,644
Borrowings	-	-	6,461	6,461
Other Financial Liabilities				
- Accommodation Bonds	-	-	1,606	1,606
- Patient Trust Accounts	-	-	174	174
Total Financial Liabilities (ii)	**-**	**-**	**105,885**	**105,885**
2016				
Contractual Financial Assets				
Cash and Cash Equivalents	52,750	-	-	52,750
Receivables				
- Trade Debtors	18,969	-	-	18,969
- Other Receivables	35,441	-	-	35,441
Other Financial Assets				
- Shares in Other Entities	-	315	-	315
Total Financial Assets (i)	**107,160**	**315**	**-**	**107,475**
Financial Liabilities				
Payables	-	-	77,964	77,964
Borrowings	-	-	1,951	1,951
Other Financial Liabilities				
- Accommodation Bonds	-	-	2,607	2,607
- Patient Trust Accounts	-	-	175	175
Total Financial Liabilities (ii)	**-**	**-**	**82,697**	**82,697**

(i) The total amount of f inancial assets disclosed here excludes statutory receivables (i.e. GST input tax credit recoverable)

(ii) The total amount of financial liabilities disclosed here excludes statutory payables (i.e. Taxes payable)

Note 7.1: Financial instruments (continued)

(b) Net holding gain/(loss) on financial instruments by category

	Net holding gain/(loss) $'000	Total interest income / (expense) $'000	Impairment loss $'000	Total $'000
2017				
Financial Assets				
Cash and Cash Equivalents [(i)]	-	1,850	-	1,850
Total Financial Assets	**-**	**1,850**	**-**	**1,850**
Total Financial Liabilities	**-**	**-**	**-**	**-**
2016				
Financial Assets				
Cash and Cash Equivalents [(i)]	-	2,221	-	2,221
Available for Sale [(i)]	1,189	-	-	1,189
Total Financial Assets	**1,189**	**2,221**	**-**	**3,410**
Total Financial Liabilities	**-**	**-**	**-**	**-**

(i) For cash and cash equivalents, loans or receivables and available-for-sale financial assets, the net gain or loss is calculated by taking the movement in the fair value of the asset, interest revenue, plus or minus foreign exchange gains or losses arising from revaluation of the financial assets, and minus any impairment recognised in the net result.

(c) Credit Risk

Credit risk arises from the contractual financial assets of Melbourne Health, which comprise cash and deposits, non-statutory receivables and available for sale contractual financial assets. Melbourne Health's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to the Health Service. Credit risk is measured at fair value and is monitored on a regular basis.

Credit risk associated with Melbourne Health's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, it is Melbourne Health's policy to only deal with entities with high credit ratings of a minimum Triple-B rating and to obtain sufficient collateral or credit enhancements, where appropriate.

In addition, Melbourne Health does not engage in hedging for its contractual financial assets and mainly obtains contractual financial assets that are on fixed interest, except for cash assets, which are mainly cash at bank. As with the policy for debtors, Melbourne Health's policy is to only deal with banks with high credit ratings.

Provision of impairment for contractual financial assets is recognised when there is objective evidence that Melbourne Health will not be able to collect a receivable. Objective evidence includes financial difficulties of the debtor, default payments, receivables which are more than 60 days overdue, and changes in debtor credit ratings.

Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents Melbourne Health's maximum exposure to credit risk without taking account of the value of any collateral obtained.

Note 7.1: Financial instruments (continued)

Credit quality of contractual financial assets that are neither past due nor impaired

2017	Financial institutions (AAA to A- credit rating) $'000	Government agencies (AAA credit rating) $'000	Government agencies (BBB credit rating) $'000	Other (min BBB to B-credit rating) $'000	Total $'000
Financial Assets					
Cash and Cash Equivalents	8,513	57,499	-	-	66,012
Loans and Receivables (i)					
- Trade Debtors	-	14,786	-	20,724	35,510
- Patient Fees	-	-	-	12,074	12,074
- Inter Hospital Debtors	-	13,218	-	-	13,218
- Accrued Revenue	-	-	-	9,151	9,151
Available for Sale					
- Shares in Other Entities	-	-	-	1	1
Total Financial Assets	**8,513**	**85,503**	-	**41,950**	**135,966**
2016					
Financial Assets					
Cash and Cash Equivalents	10,151	42,599	-	-	52,750
Loans and Receivables (i)					
- Trade Debtors	-	7,154	-	11,815	18,969
- Patient Fees	-	-	-	12,608	12,608
- Inter Hospital Debtors	-	14,246	-	-	14,246
- Accrued Revenue	-	-	-	8,587	8,587
Available for Sale					
- Shares in Other Entities	-	-	-	315	315
Total Financial Assets	**10,151**	**63,999**	-	**33,325**	**107,475**

(i) The total amounts disclosed here exclude statutory amounts (e.g. amounts ow ing from Victorian Government and GST input tax credit recoverable).

Ageing analysis of Financial Assets as at 30 June

2017	Consolidated Carrying Amount $'000	Not Past Due and Not Impaired $'000	Past Due But Not Impaired				Impaired Financial Assets $'000
			Less than 1 Month $'000	1-3 Months $'000	3 months - 1 Year $'000	1-5 Years $'000	
Financial Assets							
Cash and Cash Equivalents	66,012	66,012	-	-	-	-	-
Loans and Receivables (i)							
- Trade Debtors	35,510	29,188	3,459	1,115	1,748	-	-
- Patient Fees	12,074	4,150	2,600	1,668	3,656	-	-
- Inter Hospital Debtors	13,218	11,159	2,059	-	-	-	-
- Accrued Revenue	9,151	9,151	-	-	-	-	-
Available for Sale							
- Shares in Other Entities	1	1	-	-	-	-	-
Total Financial Assets	**135,966**	**119,661**	**8,118**	**2,783**	**5,404**	-	-
2016							
Financial Assets							
Cash and Cash Equivalents	52,750	52,750	-	-	-	-	-
Loans and Receivables (i)							
- Trade Debtors	18,969	15,371	2,408	539	651	-	-
- Patient Fees	12,608	6,579	1,994	1,870	2,165	-	-
- Inter Hospital Debtors	14,246	12,319	1,927	-	-	-	-
- Accrued Revenue	8,587	8,587	-	-	-	-	-
Available for Sale							
- Shares in Other Entities	315	315	-	-	-	-	-
Total Financial Assets	**107,475**	**95,921**	**6,329**	**2,409**	**2,816**	-	-

(i) Ageing analysis of financial assets excludes statutory financial assets (i.e GST input tax credit).

Note 7.1: Financial instruments (continued)

Contractual financial assets that are either past due or impaired

There are no material financial assets which are individually determined to be impaired. Currently Melbourne Health does not hold any collateral as security nor credit enhancements relating to its financial assets.

There are no financial assets that have had their terms renegotiated so as to prevent them from being past due or impaired, and they are stated at their carrying amounts as indicated. The ageing analysis table above discloses the ageing only of contractual financial assets that are past due but not impaired.

(d) Liquidity Risk

Liquidity risk is the risk that Melbourne Health would be unable to meet its financial obligations as and when they fall due.

Melbourne Health's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed on the balance sheet. Melbourne Health manages its liquidity risk via daily, weekly, monthly and annual cash flow forecasts.

The following table discloses the contractual maturity analysis for Melbourne Health's financial liabilities. For interest rates applicable to each class of liability refer to individual notes to the financial statements.

Maturity analysis of Financial Liabilities as at 30 June

			Maturity Dates			
2017	**Carrying Amount $'000**	**Nominal Amount $'000**	**Less than 1 Month $'000**	**1-3 Months $'000**	**3 months - 1 Year $'000**	**1-5 Years $'000**
Financial Liabilities						
At amortised cost						
Payables	97,644	97,644	71,172	24,490	1,982	-
Borrowings	6,461	6,461	-	-	412	6,049
Other Financial Liabilities [(i)]						
- Accommodation Bonds	1,606	1,606	-	126	680	800
- Patient Trusts	174	174	174	-	-	-
Total Financial Liabilities	**105,885**	**105,885**	**71,346**	**24,616**	**3,074**	**6,849**
2016						
Financial Liabilities						
At amortised cost						
Payables	77,964	77,964	58,669	18,406	889	-
Borrowings	1,951	1,951	-	-	-	1,951
Other Financial Liabilities [(i)]						
- Accommodation Bonds	2,607	2,607	479	345	782	1,001
- Patient Trusts	175	175	175	-	-	-
Total Financial Liabilities	**82,697**	**82,697**	**59,323**	**18,751**	**1,671**	**2,952**

(i) Ageing analysis of financial liabilities excludes statutory financial liabilities (i.e GST payable)

Note 7.1: Financial instruments (continued)

(e) Market Risk

Melbourne Health's exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraph below.

Currency Risk

Melbourne Health is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitment and settlement.

Interest Rate Risk

Exposure to interest rate risk might arise primarily through Melbourne Health's interest bearing liabilities. Minimisation of risk is achieved by mainly undertaking fixed rate or non-interest bearing financial instruments. For financial liabilities, Melbourne Health mainly undertakes financial liabilities with relatively even maturity profiles.

Cash flow interest rate risk is the risk that the future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

Melbourne Health has minimal exposure to cash flow interest rate risks through its cash, deposits and term deposits that are at floating rate.

Melbourne Health manages this risk by mainly undertaking fixed rate or non-interest bearing financial instruments with relatively even maturity profiles, with only insignificant amounts of financial instruments at floating rate. Management has concluded for cash at bank, as financial assets that can be left at floating rate without necessarily exposing Melbourne Health to significant bad risk, management monitors movement in interest rates on a daily basis.

Interest rate exposure of financial assets and liabilities as at 30 June

	Weighted Average Effective Interest Rate (%)	Carrying Amount	Interest Rate Exposure		
			Fixed Interest Rate	Variable Interest Rate	Non-Interest Bearing
2017		$'000	$'000	$'000	$'000
Financial Assets					
Cash and Cash Equivalents	1.84%	66,012	36,091	29,921	-
Loans and Receivables (i)					
- Trade Debtors		35,510	-	-	35,510
- Patient Fees		12,074	-	-	12,074
- Inter Hospital Debtors		13,218	-	-	13,218
- Accrued Revenue		9,151	-	-	9,151
Available for Sale					
- Shares in Other Entities		1	-	-	1
		135,966	**36,091**	**29,921**	**69,954**
Financial Liabilities					
At amortised cost					
Payables		97,644	-	-	97,644
Borrowings		6,461	-	-	6,461
Other Financial Liabilities (i)					
- Accommodation Bonds		1,606	-	1,606	-
- Patient Trusts		174	-	174	-
		105,885	**-**	**1,780**	**104,105**
2016					
Financial Assets					
Cash and Cash Equivalents	2.11%	52,750	32,350	20,399	-
Loans and Receivables (i)					
- Trade Debtors		18,969	-	-	18,969
- Patient Fees		12,608	-	-	12,608
- Inter Hospital Debtors		14,246	-	-	14,246
- Accrued Revenue		8,587	-	-	8,587
Available for Sale					
- Shares in Other Entities		315	-	-	315
		107,475	**32,350**	**20,399**	**54,725**
Financial Liabilities					
At amortised cost					
Payables		77,964	-	-	77,964
Borrowings		1,951	-	-	1,951
Other Financial Liabilities (i)					
- Accommodation Bonds		2,607	-	2,607	-
- Patient Trusts		175	-	175	-
		82,697	**-**	**2,782**	**79,915**

(i) The carrying amount excludes statutory financial assets and liabilities (i.e. GST input tax credit and GST payable).

Note 7.1: Financial instruments (continued)

Sensitivity Disclosure Analysis

Taking into account past performance, future expectations, economic forecasts and management's knowledge and experience of the financial markets, Melbourne Health believes the following movements are 'reasonably possible' over the next 12 months (Base rates are sourced from the Reserve Bank of Australia):

- A shift of +0.25% and -0.25% in market interest rates (AUD) from year-end rates of 1.50%;

The following table discloses the impact on net operating result and equity for each category of financial instrument held by Melbourne Health at year end as presented to key management personnel, if changes in the relevant risk occur.

	Carrying Amount	Interest Rate Risk -0.25%		Interest Rate Risk +0.25%		Other Price Risk 0.00%		Other Price Risk 0.00%	
2017	**$'000**	**Profit $'000**	**Equity $'000**	**Profit $'000**	**Equity $'000**	**Profit $'000**	**Equity $'000**	**Profit $'000**	**Equity $'000**
Financial Assets									
Cash and Cash Equivalents	66,012	(165)	(165)	165	165	-	-	-	-
Loans and Receivables [(i)]									
- Trade Debtors	35,510	-	-	-	-	-	-	-	-
- Patient Fees	12,074	-	-	-	-	-	-	-	-
- Inter Hospital Debtors	13,218	-	-	-	-	-	-	-	-
- Accrued Revenue	9,151	-	-	-	-	-	-	-	-
Available for Sale									
- Shares in Other Entities	1	-	-	-	-	-	-	-	-
Financial Liabilities									
At amortised cost									
Payables	97,644	-	-	-	-	-	-	-	-
Borrowings	6,461	-	-	-	-	-	-	-	-
Other Financial Liabilities [(i)]									
- Accommodation Bonds	1,606	-	-	-	-	-	-	-	-
- Patient Trusts	174	-	-	-	-	-	-	-	-
		(165)	**(165)**	**165**	**165**	**-**	**-**	**-**	**-**

	Carrying Amount	Interest Rate Risk -0.25%		Interest Rate Risk +0.25%		Other Price Risk 0.00%		Other Price Risk 0.00%	
	$'000	**Profit $'000**	**Equity $'000**	**Profit $'000**	**Equity $'000**	**Profit $'000**	**Equity $'000**	**Profit $'000**	**Equity $'000**
2016									
Financial Assets									
Cash and Cash Equivalents	52,750	(132)	(132)	132	132	-	-	-	-
Loans and Receivables [(i)]									
- Trade Debtors	18,969	-	-	-	-	-	-	-	-
- Patient Fees	12,608	-	-	-	-	-	-	-	-
- Inter Hospital Debtors	14,246	-	-	-	-	-	-	-	-
- Accrued Revenue	8,587	-	-	-	-	-	-	-	-
Available for Sale									
- Shares in Other Entities	315	-	-	-	-	-	-	-	-
Financial Liabilities									
At amortised cost									
Payables	77,964	-	-	-	-	-	-	-	-
Borrowings	1,951	-	-	-	-	-	-	-	-
Other Financial Liabilities [(i)]									
- Accommodation Bonds	2,607	-	-	-	-	-	-	-	-
- Patient Trusts	175	-	-	-	-	-	-	-	-
		(132)	**(132)**	**132**	**132**	**-**	**-**	**-**	**-**

(i) The carrying amount excludes statutory financial assets and liabilities (i.e. GST input tax credit and GST payable).

Note 7.1: Financial instruments (continued)

(f) Fair Value

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:

- Level 1 - the fair value of financial instrument with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices;
- Level 2 - the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, either directly or indirectly; and
- Level 3 - the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

Melbourne Health considers that the carrying amount of financial instrument assets and liabilities recorded in the financial statements to be a fair approximation of their fair values because of the short-term nature of the financial instruments and the expectation that they will be paid in full.

The following table shows that the fair values of most of the contractual financial assets and liabilities are the same as the carrying amounts.

Comparison between carrying amount and fair value

	Consolidated Carrying Amount 2017 $'000	Fair value 2017 $'000	Consolidated Carrying Amount 2016 $'000	Fair value 2016 $'000
Financial Assets				
Cash and Cash Equivalents	66,012	66,012	52,750	52,750
Loans and Receivables (i)				
- Trade Debtors	35,510	35,510	18,969	18,969
- Patient Debtors	12,074	12,074	12,608	12,608
- Inter Hospital Debtors	13,218	13,218	14,246	14,246
- Accrued Revenue	9,151	9,151	8,587	8,587
Available for Sale				
- Shares in Other Entities	1	1	315	315
Total Financial Assets	**135,966**	**135,966**	**107,475**	**107,475**
Financial Liabilities				
At amortised cost				
Payables	97,644	97,644	77,964	77,964
Borrowings	6,461	6,461	1,951	1,951
Other Financial Liabilities (i)				
- Accommodation Bonds	1,606	1,606	2,607	2,607
- Patient Trusts	174	174	175	175
Total Financial Liabilities	**105,885**	**105,885**	**82,697**	**82,697**

(i) The carrying amount excludes types of statutory f inancial assets and liabilities (i.e. GST input tax credit and GST payable).

Financial assets measured at fair value

	Carrying Amount as at 30 June	Fair value measurement at end of reporting period using:		
2017	**$'000**	**Level 1 $'000**	**Level 2 $'000**	**Level 3 $'000**
Financial assets at fair value through profit & loss				
Available for Sale Securities				
- Shares	1	-	1	-
Total Financial Assets	**1**	**-**	**1**	**-**
2016				
Financial assets at fair value through profit & loss				
Available for Sale Securities				
- Shares	315	-	315	-
Total Financial Assets	**315**	**-**	**315**	**-**

There have been no transfers between levels during the period.

Note 7.1: Financial instruments (continued)

The fair value of the financial assets and liabilities is included at the amount at which the instrument could be exchanged in a current transaction between willing parties, other than in a forced or liquidation sale.

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of Melbourne Health's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation*. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

Where relevant, for note disclosure purposes, a distinction is made between those financial assets and financial liabilities that meet the definition of financial instruments in accordance with AASB 132 and those that do not.

The following refers to financial instruments unless otherwise stated.

Categories of non-derivative financial instruments:

Financial assets and liabilities at fair value through profit or loss

Financial assets are categorised as fair value through profit or loss at trade date if they are classified as held for trading or designated as such upon initial recognition. Financial instrument assets are designated at fair value through profit or loss on the basis that the financial assets form part of a group of financial assets that are managed by Melbourne Health based on their fair values, and have their performance evaluated in accordance with documented risk management and investment strategies.

Financial instruments at fair value through profit or loss are initially measured at fair value and attributable transaction costs are expensed as incurred. Subsequently, any changes in fair value are recognised in the net result as other comprehensive income. Any dividend or interest on a financial asset is recognised in the net result for the year.

Reclassification of financial instruments at fair value through profit or loss

Financial instrument assets that meet the definition of loans and receivables may be reclassified out of the fair value through profit and loss category into the loans and receivables category, where they would have met the definition of loans and receivables had they not been required to be classified as fair value through profit and loss. In these cases, the financial instrument assets may be reclassified out of the fair value through profit and loss category, if there is the intention and ability to hold them for the foreseeable future or until maturity.

Loans and receivables

Loans and receivables are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets are initially recognised at fair value plus any directly attributable transaction costs.

Subsequent to initial measurement, loans and receivables are measured at amortised cost using the effective interest method, less any impairment.

Loans and receivables category includes cash and deposits (refer to Note 6.2), trade receivables, loans and other receivables, but not statutory receivables.

Held-to-maturity investments

If Melbourne Health has the positive intent and ability to hold nominated investments to maturity, then such financial assets may be classified as held to maturity. Held to maturity financial assets are recognised initially at fair value plus any directly attributable transaction costs. Subsequent to initial recognition held to maturity financial assets are measured at amortised cost using the effective interest method, less any impairment losses.

Melbourne Health makes limited use of this classification because any sale or reclassification of more than an insignificant amount of held to maturity investments not close to their maturity, would result in the whole category being reclassified as available for sale. Melbourne Health would also be prevented from classifying investment securities as held to maturity for the current and the following two financial years.

Financial liabilities at amortised cost

Financial instrument liabilities are initially recognised on the date they are originated. They are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, these financial instruments are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in profit and loss over the period of the interest-bearing liability, using the effective interest rate method.

Financial instrument liabilities measured at amortised cost include all of Melbourne Health's contractual payables, deposits held and advances received and interest-bearing arrangements other than those designated at fair value through profit or loss.

Net gain/(loss) on financial instruments

Net gain/(loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments that are designated at fair value through profit or loss or held-for-trading;
- impairment and reversal of impairment for financial instruments at amortised cost; and
- disposals of financial assets and derecognition of financial liabilities.

Revaluations of financial instruments at fair value

The revaluation gain/(loss) on financial instruments at fair value excludes dividends or interest earned on financial assets.

Note 8: Other disclosures

This section includes additional material disclosures required by accounting standards or otherwise, for the understanding of this financial report.

Structure

8.1 Equity
8.2 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities
8.3 Operating segments
8.4 Responsible persons disclosures
8.5 Executive officer disclosures
8.6 Related parties
8.7 Remuneration of auditors
8.8 Ex-gratia expenses
8.9 Other economic flows included in net result
8.10 Jointly controlled operations and assets
8.11 AASBs issued that are not yet effective
8.12 Events occurring after the balance sheet date
8.13 Economic dependency

Note 8.1: Equity

	Consolidated 2017 $'000	Consolidated 2016 $'000
(a) Surpluses		
Property, Plant & Equipm ent Revaluation Surplus [1]		
Balance at the beginning of the reporting period	332,382	300,861
Revaluation Increments/(Decrements)		
- Land	-	31,521
- Plant and Equipment/Motor Vehicle	247	-
Balance at the end of the reporting period*	**332,629**	**332,382**
* Represented by:		
- Land	164,396	164,396
- Buildings	166,163	166,163
- Plant and Equipment/Motor Vehicle	2,070	1,823
	332,629	**332,382**
Financial Assets Available-for-Sale Revaluation Surplus [2]		
Balance at the beginning of the reporting period	-	1,872
Valuation gain/(loss) recognised	-	(1,872)
Balance at end of the reporting period	**-**	**-**
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	39,377	33,643
Transfer to and from Restricted Specific Purpose Surplus	1,892	5,734
Balance at the end of the reporting period	**41,269**	**39,377**
Total Surpluses	**373,898**	**371,759**
(b) Contributed Capital		
Balance at the beginning of the reporting period	371,760	358,751
Transfers to Contributed Capital	1,734	13,009
Balance at the end of the reporting period	**373,494**	**371,760**
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	(192,533)	(160,596)
Net Result for the Year	(12,681)	(26,188)
Transfers to and from Surplus	(1,892)	(5,734)
Other - VCCC	-	(15)
Balance at the end of the reporting period	**(207,106)**	**(192,533)**
Total Equity at end of financial year	**540,286**	**550,986**

(1) The property, plant & equipment, motor vehicle asset revaluation surplus arises on the revaluation of property, plant & equipment and motor vehicle.

(2) The financial assets available-for-sale revaluation surplus arises on the revaluation of available-for-sale financial assets. Where a revalued financial asset is sold, that portion of the reserve which relates to the financial asset, and is effectively realised, is recognised in the net result. Where a revalued financial asset is impaired, that portion of the reserve which relates to that financial asset is recognised in the net result.

Note 8.1: Equity (continued)

Contributed Capital

Consistent with Australian Accounting Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* and FRD 119A *Contributions by Owners*, appropriations for additions to the net asset base have been designated as contributed capital. Other transfers that are in the nature of contributions or distributions that have been designated as contributed capital are also treated as contributed capital.

Property, Plant & Equipment Revaluation Surplus

The asset revaluation surplus is used to record increments and decrements on the revaluation of non-current physical assets.

Financial Asset Available-for-Sale Revaluation Surplus

The available-for-sale revaluation surplus arises on the revaluation of available-for-sale financial assets. Where a revalued financial asset is sold that portion of the surplus which relates to that financial asset is effectively realised, and is recognised in the comprehensive operating statement. Where a revalued financial asset is impaired that portion of the surplus which relates to that financial asset is recognised in the comprehensive operating statement.

Restricted Specific Purpose Surplus

A restricted specific purpose surplus is established where Melbourne Health has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

Note 8.2: Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities

	Consolidated 2017 $'000	Consolidated 2016 $'000
Net Result for the Year	(12,681)	(26,188)
Non-cash movements:		
Depreciation & Amortisation	52,336	48,574
Provision for Doubtful Debts	(496)	856
DHHS Loan discount	(318)	21
Assets Provided Free of Charge	-	6,027
Movements included in investing and financing activities		
Net (Gain)/Loss from Disposal of Non Financial Physical Assets	303	130
Net (Gain)/Loss from Disposal of Financial Assets	314	(1,189)
Movements in assets and liabilities:		
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	(21,279)	(12,234)
(Increase)/Decrease in Prepayments	(6,768)	(7,981)
Increase/(Decrease) in Payables	20,370	9,247
Increase/(Decrease) in Provisions	18,309	15,180
Change in Inventories	(358)	(40)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**49,732**	**32,403**

	Acute		Mental Health		RAC		Other		Consolidated	
	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000
REVENUE										
External Segment Revenue	737,701	680,203	331,459	316,502	15,603	19,109	29,758	28,402	1,114,521	1,044,216
Total Revenue	**737,701**	**680,203**	**331,459**	**316,502**	**15,603**	**19,109**	**29,758**	**28,402**	**1,114,521**	**1,044,216**
EXPENSES										
External Segment Expenses	(749,335)	(699,643)	(336,686)	(325,548)	(15,849)	(19,656)	(30,227)	(29,214)	(1,132,097)	(1,074,061)
Total Expens es	**(749,335)**	**(699,643)**	**(336,686)**	**(325,548)**	**(15,849)**	**(19,656)**	**(30,227)**	**(29,214)**	**(1,132,097)**	**(1,074,061)**
Net Result from ordinary activitie s	**(11,634)**	**(19,440)**	**(5,227)**	**(9,046)**	**(246)**	**(547)**	**(469)**	**(812)**	**(17,576)**	**(29,845)**
Interest Income	-	-	-	-	-	-	1,997	2,598	1,997	2,598
Net Result After Capital and Specific Items	**(11,634)**	**(19,440)**	**(5,227)**	**(9,046)**	**(246)**	**(547)**	**1,528**	**1,786**	**(15,579)**	**(27,247)**
OTHER INFORMATION										
Segment Assets	583,191	553,426	262,035	257,513	12,335	15,548	23,526	23,109	881,087	849,596
Total Assets	**583,191**	**553,426**	**262,035**	**257,513**	**12,335**	**15,548**	**23,526**	**23,109**	**881,087**	**849,596**
Segment Liabilities	(225,576)	(194,514)	(101,354)	(90,509)	(4,771)	(5,465)	(9,100)	(8,122)	(340,801)	(298,610)
Total Liabilities	**(225,576)**	**(194,514)**	**(101,354)**	**(90,509)**	**(4,771)**	**(5,465)**	**(9,100)**	**(8,122)**	**(340,801)**	**(298,610)**
Acquisition of Property, Plant and Equipment and Intangible Assets	27,820	36,153	12,500	16,822	588	1,016	1,123	1,510	42,031	55,501
Depreciation & Amortisation Expense	34,641	31,641	15,565	14,723	733	889	1,397	1,321	52,336	48,574

Note 8.3: Operating segments (continued)

The major products/services from which the above segments derive revenue are:

Acute
Admitted Patient Services (Admitted Patients) comprises all recurrent health revenue/expenditure on admitted patient services, where services are delivered in:

- Public hospitals
- Free standing day hospital facilities
- Palliative care facilities
- Rehabilitation facilities
- Alcohol and drug treatment units
- Hospitals specialising in dental services, hearing and ophthalmic aids

This category also includes recurrent health revenue/ expenditure on admitted patient services where service delivery is contracted to private hospitals or treatment facilities as well as recurrent funds for scope patient transport, training, research and telemedicine where it relates to admitted patient services.

Outpatient Services (Outpatients) comprises all recurrent health revenue/expenditure on public hospital type outpatient services, where services are delivered in:

- Public hospital outpatient clinics
- Free standing day hospital facilities
- Rehabilitation facilities
- Alcohol and drug treatment units
- Outpatient clinics specialising in ophthalmic aids or palliative care

This category includes recurrent health revenue/ expenditure for scope patient transport, training, research and telemedicine where it relates to outpatient services.

Emergency Department Services (EDS) comprises all recurrent health revenue/expenditure on emergency department services that are available free of charge to public patients.

This category includes recurrent health expenditure/ revenue for scope patient transport, training, research and telemedicine where it relates to emergency department services.

Off Campus, Ambulatory Services (Ambulatory) comprises all recurrent health revenue/expenditure on public hospital type services provided under the following agreements:

- Services that are provided or received by hospitals (or area health services) but are delivered/received outside a hospital campus.
- Services which have moved from a hospital to a community setting since June 1998.
- Services which fall within the agreed scope of inclusions under the new system, which have never been delivered within hospitals i.e. in rural/ remote regions.

This category includes recurrent health revenue/ expenditure for scope patient transport, training, research and telemedicine where it relates to off-campus, ambulatory services.

Mental Health
Mental Health Services (Mental Health) comprises all recurrent health revenue/expenditure on specialised mental health services (child and adolescent, general and adult, community and forensic) managed or funded by the state or territory health administrations and includes:

- Admitted patient services (including forensic mental health)
- Outpatient services
- Emergency department services (where it is possible to separate emergency department mental health services)
- Community-based services
- Residential and ambulatory services

This category includes recurrent health expenditure for scope patient transport, training, research and telemedicine where it relates to mental health services.

RAC
- Residential Aged Care comprises of residential high care and low care facilities.

Other
Other comprises revenue/expenditure for services not separately classified above, including:

- Aged Care including Home and Community Care (HACC) programs, Allied Health, Aged Care Assessment and support services
- Public Health Services including Laboratory testing, Blood Borne Viruses/Sexually Transmitted Infections clinical services, Koori Health liaison officers, immunisation and screening services
- Drugs Services including drug withdrawal, counselling and the needle and syringe program
- Disability Services including aids and equipment and flexible support packages to people with a disability
- Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services
- Health and Community Initiatives
- Clinical support, infrastructure and corporate
- Business Units; Diagnostics laboratory and medical imaging services

Geographical Segment
Melbourne Health operates predominantly in Melbourne, Victoria. Effectively all of revenue, net surplus from ordinary activities and segment assets relate to operations in Melbourne, Victoria.

Note 8.4: Responsible persons disclosures

In accordance with the Ministerial Directions issued by the Minister for Finance under the *Financial Management Act 1994*, the following disclosures are made regarding responsible persons for the reporting period.

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister f or Health and Minister for Ambulance Services	1/07/2016 - 30/06/2017
The Honourable Martin Foley, Minister f or Housing, Disability and Ageing and Minister f or Mental Health	1/07/2016 - 30/06/2017
Governing Board	
Mr Robert Doyle, AC	1/07/2016 - 30/06/2017
Mr Eugene Arocca	1/07/2016 - 30/06/2017
Mrs Jane Bell	1/07/2016 - 30/06/2017
Mr Michael Gorton, AM	1/07/2016 - 30/06/2017
Ms Penelope Hutchinson	1/07/2016 - 30/06/2017
Ms Angela Jackson	1/07/2016 - 30/06/2017
Ms Jennif er Kanis	1/07/2016 - 30/06/2017
Prof essor Shitij Kapur	20/12/2016 - 30/06/2017
Mr Gregory Tw eedly	1/07/2016 - 30/06/2017
Dr Victoria Atkinson	1/07/2016 - 19/05/2017
Accountable Officers	
Prof essor Christine Kilpatrick	1/05/2017 - 30/06/2017
Mr Adam Horsburgh	17/10/2016 - 30/04/2017
Dr Gareth Goodier	1/07/2016 - 16/10/2016

Remuneration

Remuneration received or receivable by responsible persons w as in the range: $0 – $548,000 ($0 – $532,000 in 2015-16).

Note 8.5: Executive officer disclosures

Remuneration of executives

The number of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the table below. Total annualised employee equivalent provides a measure of full time equivalent executive officers over the reporting period.

Remuneration comprises employee benefits in all forms of consideration paid, payable or provided in exchange for services rendered, and is disclosed in the following categories.

Short-term employee benefits include amounts such as wages, salaries, annual leave or sick leave that are usually paid or payable on a regular basis, as well as non-monetary benefits such as allowances and free or subsidised goods or services.

Post-employment benefits include pensions and other retirement benefits paid or payable on a discrete basis when employment has ceased.

Other long-term benefits include long service leave, other long-service benefit or deferred compensation.

Termination benefits include termination of employment payments, such as severance packages.

Several factors affected total remuneration payable to executives over the year. A number of employment contracts were completed during the year and negotiated and a number of executives received bonus payments during the year. These bonus payments depend on the terms of individual employment contracts.

A number of executive officers retired or resigned in the past year. This has had a significant impact on total remuneration figures due to the inclusion of annual leave, long-service leave and termination benefits.

Remuneration of executive officers (including Key Management Personnel disclosed in Note 8.6)	**Total Remuneration**	
	2017 $'000	**2016 [i] $'000**
Short term employee benefits	2,901	
Post-employment benefits	227	
Other long-term benefits	397	
Termination benefits	693	
Total remuneration [i][ii]	**4,218**	
Total number of executives	**9**	**11**
Total annualised employee equivalents (AEE) [iii]	**8**	**9**

(i) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD 21B. Remuneration previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable, excluding reimbursement of out-of-pocket expenses, including any amount received or receivable from a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015-16 reporting period.

(ii) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of Melbourne Health under AASB 124 Related Party Disclosures and are also reported within the related parties note disclosure (Note 8.6)

(iii) Annualised employee equivalent is based on the time fraction worked over the reporting period.

Note 8.6: Related Parties

The hospital is a wholly owned and controlled entity of the State of Victoria. Related parties of the hospital include:

- all key management personnel and their close family members;
- all cabinet ministers and their close family members; and
- all hospitals and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

All related party transactions have been entered into on an arm's length basis.

Key management personnel (KMP) of the hospital include the Portfolio Ministers and Cabinet Ministers and KMP as determined by the hospital. The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the *Parliamentary Salaries and Superannuation Act 1968*, and is reported within the Department of Parliamentary Services' Financial Report.

Compensation	2017 $'000
Short term employee benefits	3,777
Post-employment benefits	344
Other long-term benefits	943
Termination benefits	693
Total	**5,757**

Transactions with key management personnel and other related parties

Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the *Public Administration Act 2004* and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements.

Outside of normal citizen type transactions with Melbourne Health, there were no related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

Significant transactions with government-related entities

Melbourne Health received funding from the Department of Health and Human Services of $815m (2016: $744m).

Note 8.7: Remuneration of auditors

	2017 $'000	2016 $'000
Victorian Auditor-General's Office		
Audit or review of financial statement	220	225
	220	**225**

Note 8.8: Ex-gratia expenses

Melbourne Health has made the following ex gratia expenses:	2017 $'000	2016 $'000
Redundancy payment	-	13
Total ex-gratia expenses	**-**	**13**

Includes ex-gratia for both individual items and in aggregate that are greater than or equal to $5,000.

Note 8.9: Other economic flows included in net result

	2017 $'000	2016 $'000
Net gain/(loss) on non-financial assets		
Net gain/(loss) on non-financial assets	(303)	(130)
Total net gain/(loss) on non-financial assets	**(303)**	**(130)**
Net gain/(loss) on financial instruments		
Impairment of:		
Loans and receivables [(a)]	(2,499)	-
Net FX gain/(loss) arising from financial instruments	(27)	-
Net gain/(loss) on disposal of financial instruments	(314)	1,189
Total net gain/(loss) on financial instruments	**(2,840)**	**1,189**
Other gains/(losses) from other economic flows		
Net gain/(loss) arising from revaluation of long service liability	6,041	-
Total other gains/(losses) from other economic flows	**6,041**	**-**

(a) Including increase/(decrease) in provision for doubtful debts

Note 8.9: Other economic flows included in net result (continued)

Other economic flows included in net result
Other economic flows are changes in the volume or value of assets or liabilities that do not result from transactions.

Net gain/(loss) on non-financial assets
Net gain/(loss) on non-financial assets and liabilities includes realised and unrealised gains and losses as follows:

Revaluation gains/(losses) of non-financial physical assets

Refer to Note 4.2 *Property plant and equipment*

Net gain/ (loss) on disposal of non-financial assets

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is the difference between the proceeds and the carrying amount of the asset at the time. Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement.

Net gain/(loss) on financial instruments
Net gain/(loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments at fair value;
- impairment and reversal of impairment for financial instruments at amortised cost. Refer to Note 4.1 *Investments and other financial assets*; and
- disposals of financial assets and derecognition of financial liabilities.

Impairment of non-financial assets
Goodwill and intangible assets with indefinite useful lives (and intangible assets not available for use) are tested annually for impairment and whenever there is an indication that the asset may be impaired.

All other non-financial assets are assessed annually for indications of impairment, except for:

- inventories;
- assets arising from construction contracts.

If there is an indication of impairment, the assets concerned are tested as to whether their carrying amount exceeds their possible recoverable amount. Where an asset's carrying amount exceeds its recoverable amount, the difference is written-off as an expense except to the extent that the write-down can be debited to an asset revaluation surplus amount applicable to that same class of asset.

If there is an indication that there has been a change in the estimate of an asset's recoverable amount since the last impairment loss was recognised, the carrying amount shall be increased to its recoverable amount. This reversal of the impairment loss occurs only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised in prior years.

It is deemed that, in the event of the loss or destruction of an asset, the future economic benefits arising from the use of the asset will be replaced unless a specific decision to the contrary has been made. The recoverable amount for most assets is measured at the higher of depreciated replacement cost and fair value less costs of disposal. Recoverable amount for assets held primarily to generate net cash inflows is measured at the higher of the present value of future cash flows expected to be obtained from the asset and fair value less costs of disposal.

Revaluations of financial instrument at fair value
Refer to Note 7.1 *Financial instruments.*

Other gains/ (losses) from other economic flows
Other gains/ (losses) include:

a. the revaluation of the present value of the long service leave liability due to changes in the bond rate movements, inflation rate movements and the impact of changes in probability factors; and

b. transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

Change in Accounting Policy (AASB101)
The below change in accounting policies were adopted in 2016–17. As the changes in accounting policies were applicable for the 2016–17 financial year, comparative figures for 2015–16 have not been restated.

Long service leave
During the reporting period, the department issued Circulars 3/2016 and 4/2017 which advised that:

As the Department of Health and Human Services is not funded for movements in the long service leave provision resulting from changes in estimations, the department policy for funding health services is being changed to align with the Department of Treasury and Finance's treatment.

As a result of this, health services will no longer be funded by the department for the impact of the bond rate, inflation rate and probability factors changes on their long service leave balance and no corresponding payable will be recorded in the department's books relating to this.

The impact of the proposed changes to the department's policy for funding and reporting long service leave expenses is as follows:

- health services will no longer recognise grant revenue from the department for the impact of changes due to revaluations on long service leave balances; and
- gains/losses from revaluations will be reported under other the economic flows included in net result.

Doubtful debts
Bad debts not written off by mutual consent and the allowance for doubtful debts are classified as other economic flows in the net result.

Note 8.10: Jointly controlled operations and assets

Name of Entity	Principal Activity	Ownership Interest 2017 %	Ownership Interest 2016 %
Victorian Comprehensive Cancer Centre Limited	Cancer Research & Treatment	10	10

Melbourne Health's interest in assets employed in the above jointly controlled operations and assets is detailed below. The amounts are included in the financial statements and consolidated financial statements under their respective asset categories:

	2017 $'000	2016 $'000
Current Assets		
Cash and Cash Equivalents	566	256
Receivables	3	4
Other Current Assets	3	4
Total Current Assets	**572**	**264**
Non Current Assets		
Investment	1	1
Property, Plant and Equipment	3	4
Total Non Current Assets	**4**	**5**
TOTAL ASSETS	**576**	**269**
Current Liabilities		
Payables	26	18
Income in Advance	-	35
Employee Benefits and Related On-Costs	8	43
Total Current Liabilities	**34**	**96**
Non-Current Liabilities		
Employee Benefits and Related On-Costs	6	5
Total Non-Current Liabilities	**6**	**5**
TOTAL LIABILITIES	**40**	**101**
NET ASSETS	**536**	**168**
EQUITY		
Accumulated Surpluses/(Deficits)	536	168
TOTAL EQUITY	**536**	**168**

Melbourne Health's interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

	2017 $'000	2016 $'000
Revenues		
Grants	657	292
Other - Interest	9	5
Other - Revenue	22	20
Total Revenue	**688**	**317**
Expenses		
Employee Benefits	(142)	(153)
Depreciation	(1)	(1)
Other expenses	(177)	(139)
Total Expenses	**(320)**	**(293)**
Profit	**368**	**24**

Interests in jointly controlled assets or operations are consolidated by Melbourne Health.

In respect of any interest in joint operations, Melbourne Health recognises in the financial statements:

- the assets that it controls jointly;
- the liabilities that it incurs;
- expenses that it incurs jointly; and
- the share of income that it earns from selling outputs of the joint operation.

Note 8.11: AASBs issued that are not yet effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2017 reporting period. DTF assesses the impact of all these new standards and advises Melbourne Health of their applicability and early adoption where applicable.

As at 30 June 2017, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Melbourne Health has not and does not intend to adopt these standards early.

Standard/ Interpretation	Summary	Applicable for annual reporting periods beginning or ending on	Impact on financial statements
AASB 9 *Financial Instruments*	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 Jan 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. While there will be no significant impact arising from AASB 9, there will be a change to the way financial instruments are disclosed.
AASB 2010-7 *Amendments to Australian Accounting Standards arising from AASB 9* (December 2010)	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: • The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and • Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	1 Jan 2018	The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge. For entities with significant lending activities, an overhaul of related systems and processes may be needed.
AASB 2014-1 *Amendments to Australian Accounting Standards [Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 Jan 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 *Amendments to Australian Accounting Standards arising from AASB 9*	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 15 *Revenue from Contracts with Customers*	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 Jan 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications.
AASB 2014-5 *Amendments to Australian Accounting Standards arising from AASB 15*	Amends the measurement of trade receivables and the recognition of dividends. Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. Dividends are recognised in the profit and loss only when: • the entity's right to receive payment of the dividend is established; • it is probable that the economic benefits associated with the dividend will flow to the entity; and • the amount can be measured reliably.	1 Jan 2017, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.

Note 8.11: AASBs issued that are not yet effective (continued)

Standard/ Interpretation	Summary	Applicable for annual reporting periods beginning or ending on	Impact on financial statements
AASB 2016-3 *Amendments to Australian Accounting Standards – Clarifications to AASB 15*	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: • A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; • For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and • For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified for AASB 15 above.
AASB 2016-7 *Amendments to Australian Accounting Standards – Deferral of AASB15 for Not-for-Profit Entities*	This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	1 Jan 2019	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.
AASB 2016-8 *Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities*	This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments: • require non-contractual receivables arising from statutory requirements (i.e. taxes, rates and fines) to be initially measured and recognised in accordance with AASB 9 as if those receivables are financial instruments; and • clarifies circumstances when a contract with a customer is within the scope of AASB 15.	1 Jan 2019	The assessment has indicated that there will be no significant impact for the public sector, other than the impacts identified for AASB 9 and AASB 15 above.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet.	1 Jan 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of the right-of-use assets and lease liabilities will cause net debt to increase. Rather than expensing the lease payments, depreciation of right-of-use assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. No change for lessors.
AASB 1058 *Income of Not-for-Profit Entities*	This standard replaces AASB 1004 *Contributions* and establishes revenue recognition principles for transactions where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entity to further its objectives.	1 Jan 2019	The assessment has indicated that revenue from capital grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as performance obligations are satisfied. As a result, the timing recognition of revenue will change.

Note 8.12: Events occurring after the balance sheet date

Assets, liabilities, income or expenses arise from past transactions or other past events. Where the transactions result from an agreement between the Health Service and other parties, the transactions are only recognised when the agreement is irrevocable at or before the end of the reporting period.

Adjustments are made to amounts recognised in the financial statements for events which occur between the end of the reporting period and the date when the financial statements are authorised for issue, where those events provide information about conditions which existed at the reporting date. Note disclosure is made about events between the end of the reporting period and the date the financial statements are authorised for issue where the events relate to conditions which arose after the end of the reporting period that are considered to be of material interest.

No events have occurred since reporting date and date of certification of this report which will have a material effect on the information contained in the financial report.

Note 8.13: Economic dependency

The financial performance and position of Melbourne Health has improved slightly since the prior year, with the health service reporting a surplus net result before capital and specific items of $0.3m (2016: deficit $2.8m), a net current asset position of $117m (2016: $116m), resulting in a current asset ratio of 0.61 (2016: 0.56) and a cash outflow from operations of $1,088m (2016: $1,039m).

As a result of the financial performance and position, Melbourne Health has obtained a letter of support from the State Government and in particular, the Department of Health and Human Services (DHHS), confirming that the department will continue to provide Melbourne Health adequate cash flow to meet its current and future obligations up to 30 September 2018. A letter was also obtained for the previous financial year. On that basis, the financial statements have been prepared on a going concern basis.

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MELBOURNE HEALTH